**Headache Management Neurological Consultation Request**

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| Date of Referral:  |
| **Patient Information** |
| First Name: | Last Name: |
| D.O.B. (DD/MM/YYYY): | Gender: |
| Health Card #: | Version: | Expiry Date: |
| Address: |
| City:  | Postal Code: |
| Phone Number (1):  | Phone Number (2): |

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| **Reason for Referral**  |
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| If prior neuroimaging is available (i.e. MRI/CT head/neck), please include it within the referral along with any pertinent labs (i.e. renal/hepatic function).  |

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| **Referring Healthcare Provider Information** |
| Referring Provider Name:  | OHIP Billing #: |
| Address: | City: |
| Postal Code: | Phone: | Fax: |
| **Primary Healthcare Provider (If Different from Above)** |
| Referring Provider Name: |
| Address: | City: |
| Postal Code: | Phone: | Fax: |
| *Please note: Dr. Aleksenko is not accepting WSIB claims at this time.*  |