



Dr. Abdul R. Shaikh
Neurologist
Diplomat American Board of Neurology
Clinical Assistant Professor of Neurology
Fellowship Trained in Clinical Neuro-Physiology/EMG
Neuro-Muscular Disease & Vascular Neurology (Stroke)

NEUROLOGY CLINIC REFERRAL FORM

Referring provider information

Requested by: _____ Billing #: _____ Phone: _____ Fax: _____

Address: _____

Reason for Consultation:

- ☐ Neuromuscular/EMG
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Movement Disorders/Parkinson's
- ☐ TIA/Stroke
- ☐ Aging/Alzheimer's
- ☐ Muscular Dystonia/Botox
- ☐ Migraines/Headaches
- ☐ Syncope/Vertigo
- ☐ Others

Brief Description of Neurological Problem: _____

Relevant History and Previous Investigations and Results (i.e MRI, CT, EEG, EMG):

Medications: _____

Patient Information:

Name: _____ **D.O.B.:** _____ **Age:** _____

Gender: _____ **Address:** _____

City: _____ **Postal Code:** _____ **Phone:** _____

Health Card Number: _____

Please mail or fax this referral to:

Dynamic Medical
4-45 Hannover Dr, St. Catharines, ON, L2W 1A3
Phone: 905-684-9999
Fax: 905-684-9985