Catalyst for Health Medical Clinic

Dr Daniel LeBLond Electrodiagnostic Laboratory

Referral Form

Dr. Daniel LeBLond
Catalyst for Health Medical Clinic
Suite 220, 7460 Springbank Blvd S.W.
Calgary, Alberta T3H4V4
Phone: (403) 800 5596
Fax: (403) 800 9374
Toll Free: 1 (888) 8541926

***Patient Information*:**
Name: _____
Address: _____
Phone (H) _____ (W) _____
Cell: _____
PHN: _____ Gender: M / F
DOB: _____

REFERRING PHYSICIAN INFORMATION

Name:_____ **Phone:** _____

Address:_____ **Fax:**_____

_____

_____ **Practice ID # :**_____

WCB Claim No. _____ **Case Worker Name:** _____

Date of Accident _____ **Phone:** _____

***CLINICAL QUESTION*:**

	R	L	Both
Carpal Tunnel Syndrome	❑	❑	❑
Ulnar Neuropathy	❑	❑	❑
Cervical Radiculopathy	❑	❑	❑
Lumbosacral Radiculopathy	❑	❑	❑
Brachial/Lumbar Plexopathy	❑	❑	❑

❑ Polyneuropathy
❑ Myopathy
❑ Neuromuscular Junction Defect
❑ Other _____

***DOES THIS PATIENT HAVE A HISTORY OF*:**

Diabetes	*❑ Yes*	*❑ No*
Thyroid Disease	*❑ Yes*	*❑ No*
Renal Failure	*❑ Yes*	*❑ No*
Connective Tissue Disease (R.A. etc)	*❑ Yes*	*❑ No*
Ethanol Abuse	*❑ Yes*	*❑ No*
Bleeding Disorder	*❑ Yes*	*❑ No*
Anticoagulant Therapy	*❑ Yes*	*❑ No*

Is this patient in a wheelchair *❑ Yes* *❑ No*

CLINICAL INFORMATION AND REASON FOR REFERRAL: *(Please include relevant previous EMG Studies, MRI's, X-rays, Blood Work, Medication List)****

Physician's Signature: **Date:**