Department of Neuroscience Referral Form

The Alfred
Commercial Road, Prahran, 3181
Fourth Floor, Centre Block
Phone: 9076 2059 Fax: 9076 5075

Appointment Date: _____ Time: _____ AM/PM

Patient Details: (Block letters)

Surname:	First Name:	UR Number:

Address:

Date of Birth:	Ward/Unit:	IP/OP/Private	Phone Number:

Interpreter Required: Yes / No Language:

Veteran Affairs Workcover TAC (Claim No: _____)

Clinical Notes:	Test Required:
	o EMG/NCS o EEG o VER o SER: o Upper o Lower o Quantitative Sensory Test o Autonomic Study o Visual Field o Tremor Study o Botulinum Toxin Injection (for neurological disorders) o Long Term EEG Monitoring (By Neurologist referral only)
Medication:	

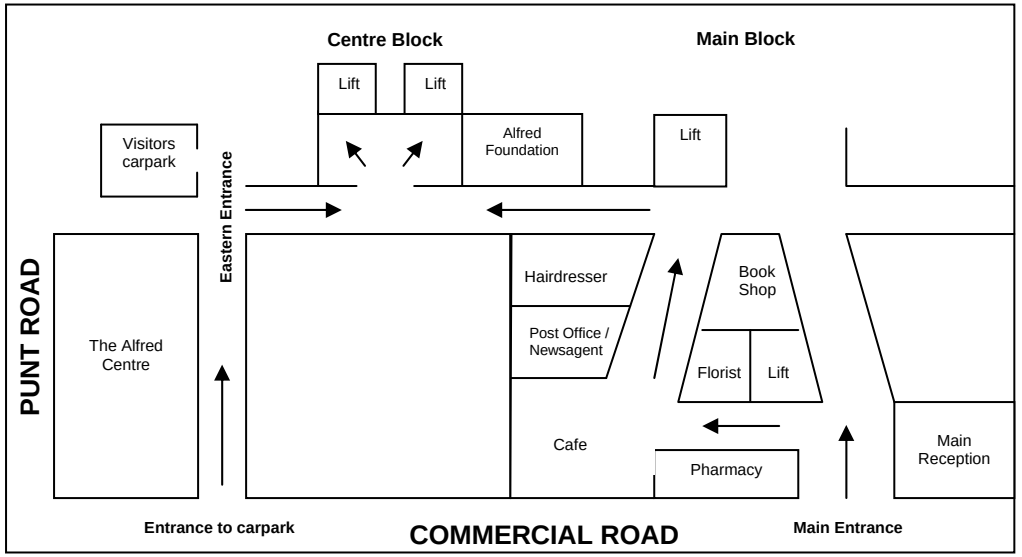
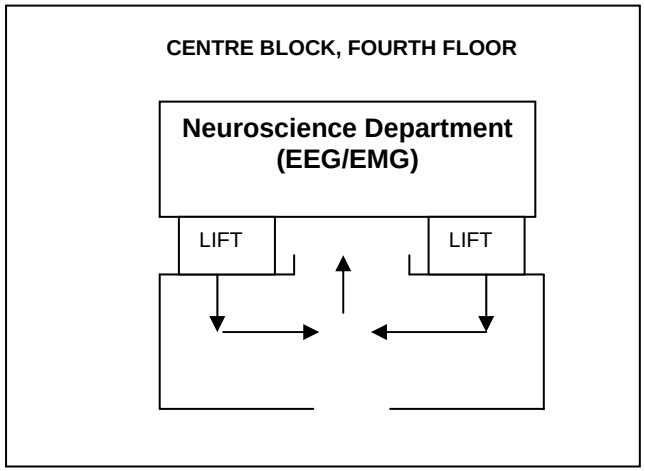
Date:	Provider Number:	Pager/Extension:

Referring Doctor:	Signature:

Report Copies To:

Directions to the Neuroscience (EEG/EMG) Department

GROUND FLOOR



FOURTH FLOOR