Referring Physician: _____

OFFICE STAMP

Trillium Brain&Spine
89 Queensway West
Suite 500, Mississauga
(905) 848-0001 ext.4
brainandspine.ca

PLEASE FAX REQUISITION TO 905-848-0003

PATIENT INFORMATION

Name:_____ **Sex:** M/F

Last First Date of Birth

Health Card:_____

Address:_____ **Unit:**_____

City:_____ **Postal Code:**_____

Telephone: (H)_____ **(W)**_____ **(C)**_____

Email:_____

PRE-EXISTING CONDITION

☐ Atrial Fibrillation/Flutter ☐ History of Cardiac Disease ☐ Hypertension ☐ TIA/Stroke

REASON FOR REFERRAL - 14 day Holter X 2

(if 1st 14 days is negative for Atrial Fibrillation, patient will be recalled for another 14 days)

☐ TIA/Stroke ☐ Atrial Fibrillation/Flutter ☐ Syncope ☐ Pacemaker/Defibrillator

STROKE LOCATION or SYMPTOMS (If Available):_____

Requesting Stroke Neurology Referral: ☐ YES ☐ NO

REASON FOR REFERRAL:_____

DOCUMENTED STROKE: ☐ YES ☐ NO

LOCATION: ☐ Cortical ☐ Subcortical ☐ Brainstem ☐ Cerebellum

Trillium Brain and Spine will contact you to schedule an appointment.
89 Queensway West, Suite 500, Mississauga, ON
Monday to Friday: 10:00am - 4:00pm • Ph: (905) 848-0001 ext.4
Please visit our website for further information at brainandspine.ca
Parking will be validated upon request