Referral Form
Neurology Consultation _ EMG _ Botulinum Toxin

ATTN TO:

Dr David Moses
Neurology and EMG service

41 Como PDE East, Mentone 3194
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FROM:

Referring DR:…………………………………………….

Prov No: …………………………………………….

Address: …………………………………………….

Fax: …………………………………………….

Patient Name: **DoB:**

Address

Contacts:

Clinical Notes:

Service(s) requested: *(Please tick)*

- ☐ **Consultation**
- ☐ **Nerve Conduction/EMG**
- ☐ **Botulinum toxin therapy for:**

Migraine _ Cervical Dystonia _ Hemi facial spasm _ Blepharospasm

Date:

Signature:

Duration of the referral: 3 months 12 months Indefinite

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