Danforth Neurology

Request for Consultation Form

235 Danforth Ave, Suite 300
Toronto, ON, M4K 1N2
Phone (647) 558-6518 Fax (647) 558-6528
www.danforthneurology.ca

Thank you for choosing Danforth Neurology. Please fill out this form completely and legibly. Please attach relevant documents so that your referral can be triaged appropriately.

Reason for Referral:

Patient Information:

Name: _____ DOB: _____

Health Card Number: _____ Version Code: _____

Address: _____ City: _____

Telephone: _____

Referring Provider Information:

Name: _____ Billing Number: _____

Address: _____

Telephone: _____ Fax: _____

Copies to: _____

Signature: _____

Our office will contact the referring doctor within two weeks of receiving a completed referral.