

**NEW PATIENT REFERRAL**

<b>Patient Name:</b>	Sex: M <input type="checkbox"/> F <input type="checkbox"/>			
<b>Date of Birth:</b>	<b>PHN:</b>			
<b>Address:</b>				
<b>Home Phone:</b> Cellphone:	<b>Work Phone:</b>			
<b>Referring Physician:</b>	<b>Billing #</b>			
<b>Date of Referral:</b>	<b>Fax:</b>			
<b>Telephone:</b>	<b>Fax:</b>			
<b>Family Physician:</b>	<b>Billing #</b>			
<b>Telephone:</b>	<b>Fax:</b>			
<b>Reason for Referral:</b> <input type="checkbox"/> First Attack of Clinical Demyelination Including: Optic Neuritis, Transverse Myelitis, etc. (within past 4 weeks) <input type="checkbox"/> Newly Diagnosed MS/NMO <input type="checkbox"/> Diagnostic Work-up for MS/NMO <input type="checkbox"/> Existing clinic patient - Please check one of the following: <input type="checkbox"/> Acute Relapse <input type="checkbox"/> Ongoing care <input type="checkbox"/> Re-evaluation <b><i>For Urgent concerns call the MS Clinic to speak with a nurse or physician</i></b>				
<b><u>Clinicians in MS and NMO Clinic - Note: All Referrals Are Reviewed and Triage to First Available</u></b>  <input type="checkbox"/> If specific clinician requested, please indicate reason here:  <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Dr. Virginia Devonshire</li> <li>• Dr. Alice Schabas</li> </ul> </td> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Dr. Robert Carruthers</li> <li>• Dr. Anthony Traboulsee</li> </ul> </td> <td style="width: 33%; vertical-align: top;"> <ul style="list-style-type: none"> <li>• Dr. Ana-Luiza Sayao</li> </ul> </td> </tr> </table> <input type="checkbox"/> Neuro-Ophthalmology		<ul style="list-style-type: none"> <li>• Dr. Virginia Devonshire</li> <li>• Dr. Alice Schabas</li> </ul>	<ul style="list-style-type: none"> <li>• Dr. Robert Carruthers</li> <li>• Dr. Anthony Traboulsee</li> </ul>	<ul style="list-style-type: none"> <li>• Dr. Ana-Luiza Sayao</li> </ul>
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<b>Special Concern/Relevant History:</b>				
<ul style="list-style-type: none"> <li>• To ensure a timely booking for the patient, please attach all relevant consult letters, MRI reports, lab reports, and previous records to this referral.</li> </ul>				
<p>The MS Clinic will call the new patient directly to book an appointment.  <b>NOTE: All referral requests are triaged &amp; prioritized to be seen in the MS Clinic</b>  <b><u>Reminder: Incomplete referral requests will be returned.</u></b></p>				
For office use only: Date records received: _____ Date Triaged: _____ Triage Code: _____				

For more information, visit our website at <https://www.ms.ubc.ca/>  
**Please complete this form in full and fax to (604) 297-9685**