NORTH QUEENSLAND
neurology

Specialist in Neurology and Neurophysiology

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REFERRAL FORM - PLEASE INDICATE - ☐ INPATIENT ☐ OUTPATIENT

Patient Details

Name: ______________________ DOB: ______________________

Address: ______________________

Phone: ______________________ Mobile: ______________________

Email: ______________________

☐ **NEUROLOGICAL CONSULTATION**

NCS/EMG

Indicate Side: ☐ Right ☐ Left ☐ Bilateral

☐ Carpal tunnel syndrome ☐ Myopathy

☐ Ulnar Neuropathy

☐ Peripheral neuropathy

☐ Common Peroneal Neuropathy

☐ Brachial/Lumbo Sacral Plexopathy

☐ Radiculopathy – Level _______

INJECTABLE THERAPY

☐ Facial spasm

☐ Blepharospasm

☐ Migraine (see website nqn.com.au for referral letter)

☐ Cervical dystonia

☐ Tremor

☐ Hyperhidrosis

EEG

☐ Routine ☐ Monitoring ☐ Ambulatory

Clinical History:

Referring Doctor Details:

Name: ______________________

Provider No: ______________________

Signature: ______________________

Date: ______________________

PROVIDER STAMP