Vancouver CoastalHealth
Djavad Mowafaghian CENTRE FOR BRAIN HEALTH

ALS & Related Disorders Program - Outpatient Referral Form

Djavad Mowafaghian Centre for Brain Health
2215 Westbrook Mall, 2nd Floor
Vancouver BC
V6T 1Z3

Phone: 604-827-1095
Fax: 604-822-2611

CLIENT DEMOGRAPHICS

Client Name: (Last) (First)	DOB: (Day) / (Month) / (Year)	Gender: ☐ M ☐ F
Home Address (street #, street name, city, postal code):		
Home/Cell Tel.#:	PHN#:	
Referring Physician: Tel.#: Fax #:	Family Physician: Tel.#:	
Primary Contact to Arrange Appointments: Tel.#: Relationship to client: Alternate Contact: Tel.#:		
Speaks & Understands English? ☐ Yes ☐ Minimal ☐ No Interpreter Required: ☐ No ☐ Yes - Language:		
Is the injury work related? ☐ No ☐ Yes – Worksafe Claim # _____ Is the injury a result of a motor vehicle accident? ☐ No ☐ Yes – ICBC Claim # _____		

Reason for Referral: **Date of Onset:**

☒ **EMG order**

Medical History and Current Medications:

Allergies: ☐ NKA ☐ Yes - List: _____

Please ensure supporting documentation is included with the referral.
Supporting documentation can include:

☐ Recent medical history (include follow up plans)

☐ Copies of specialty consultations

☐ Copies of diagnostics (CT Scans / MRI, EMG reports) and most recent lab work