



Winnipeg Regional Health Authority  
Office régional de la santé de Winnipeg  
Caring for Health À l'écoute de notre santé

**Winnipeg Multiple Sclerosis Clinic Referral**  
HSC  
820 Sherbrook Street  
Room GE-217  
Winnipeg, MB R3A 1R9  
Fax back to: (204) 787-3808  
Telephone: (204) 787-3805/  
(204) 787-7148

**Referring Doctor Information:**

Name
Address
Fax
Phone
Provider #

**Please Print**

<b>Patient Name:</b> Given Name _____ Surname _____			<b>PHIN:</b>
<b>Home Address/Postal Code:</b>			<b>MHSC:</b>
			<b>RCMP #</b>
<b>Date of Birth:</b> Day _____ Month _____ Year _____	<b>Main Phone #</b>	<b>Alternative Phone #</b>	<b>Treaty #</b>
<b>Sex:</b> <input type="checkbox"/> F <input type="checkbox"/> M	<b>Canadian Military #</b>		
<b>Family Physician (If not referring physician) – Please print name, telephone, address and fax number</b>			

<b>Reason for Referral</b>
<b>Major Concern/Symptoms</b>
<b>New Patient</b> <input type="checkbox"/> Newly diagnosed/At Risk for MS <input type="checkbox"/> Confirmation of Diagnosis <input type="checkbox"/> Moved to MB/NW Ontario <input type="checkbox"/> Other (specify) _____
<b>Referral for Follow-up</b> Name MS Physician _____  <input type="checkbox"/> Disease Modifying Treatments <input type="checkbox"/> Symptom Management (Specify) <input type="checkbox"/> Query Progression of Disease <input type="checkbox"/> Worsening in motor abilities <input type="checkbox"/> Worsening symptoms interfering with ADL <input type="checkbox"/> Worsening of cognitive function
<input type="checkbox"/> Consideration for involvement in clinical trials

<b>Required Reports and Diagnostics</b> <i>*Note: Referrals will not be processed without the following information and diagnostics.</i>
<input type="checkbox"/> *Recent Medical History and Findings
<input type="checkbox"/> *MRI Brain Location: <input type="checkbox"/> HSC <input type="checkbox"/> St.Boniface <input type="checkbox"/> Brandon <input type="checkbox"/> Boundary Trails <input type="checkbox"/> Not done <input type="checkbox"/> Other _____
<input type="checkbox"/> MRI Spine Location: <input type="checkbox"/> HSC <input type="checkbox"/> St.Boniface <input type="checkbox"/> Brandon <input type="checkbox"/> Boundary Trails <input type="checkbox"/> Not done <input type="checkbox"/> Other _____
<input type="checkbox"/> Evoked Potentials
<input type="checkbox"/> Lumbar Puncture
<input type="checkbox"/> Neurology assessment
<input type="checkbox"/> Ophthalmology assessment

Additional Comments:

Referring Physician Signature _____	Date _____
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*All patient referrals to the Winnipeg Multiple Sclerosis Clinic will be reviewed and assigned a level of priority for appointment. Referral to the MS Clinic will not guarantee that an appointment will be given.*

Date Referral received:

Priority Status for appt scheduling completed by **MS Clinic** Personnel only:  High  Moderate  Mild