Sunnybrook
HEALTH SCIENCES CENTRE

Rapid Access in Neurosurgery (RAIN) Clinic Referral Form

PATIENT IDENTIFICATION

2075 Bayview Avenue, Toronto, ON M4N 3M5 – C-Wing, Ground Floor, Room 02 (CG 02)
Phone: 416-480-4053 Fax: 416-480-5576 Email: RAINclinic@sunnybrook.ca

PATIENT INFORMATION

Name (Last, First): _____

Age:_____ Date of Birth (YYYY/MM/DD):_____

OHIP #: _____Version Code: _____ Phone #: _____

Address: _____

REASON FOR REFERRAL

Neurosurgery:

☐ Brain tumour ☐ Intracranial hemorrhage (traumatic or spontaneous)
☐ Traumatic brain injury ☐ Hydrocephalus
☐ **Other:** _____

Spine (only applicable for referrals from External Emergency Departments):

☐ Spinal degeneration with neurological deficit ☐ Spine intradural-nerve tumour
☐ Incidental vascular lesion ☐ **Other:** _____

IMAGING DONE (please include report)

☐ CT head ☐ MRI head ☐ CT spine ☐ MRI spine ☐ Other: _____
Referrals with a concern for an underlying lesion (e.g. neoplastic, vascular malformation) should have an MRI performed or pending from the referring site to facilitate the consultation.

REFERRAL URGENCY

Please see within: ☐ 1 week ☐ 2 - 4 weeks

Referring physician name:_____ Referring physician fax: _____

Referring physician address (or hospital name): _____

Referring physician email: _____ Referring physician billing number: _____

Referring physician signature: _____ Date (YYYY/MM/DD): _____

PLEASE NOTE ANY SAFETY CONSIDERATIONS FOR PATIENT BOOKING

(e.g. High falls risk, known cognitive impairment, wandering risk):

COMMENTS