



DT9294

NEUROLOGY CONSULTATION ADULT

Note: Refer to the clinical alerts on the back of the form and favor, if available, the protocols of the Accueil Clinique before filling it out.

Patient's first and last name			
Health insurance number		Year	Month
		Expiry	
Parent's first and last name			
Area code	Phone number	Area code	Phone number (alt.)
Address			
Postal code			

Raison de consultation		Échelle de priorité clinique : A : ≤ 3 jrs B : ≤ 10 jrs C : ≤ 28 jrs D : ≤ 3 mois E : ≤ 12 mois				
Neurovascular (TIA)	<input type="checkbox"/> Transient focal neurological symptoms suggestive of TIA presenting after > 14 days	C	Movement disorder	<input type="checkbox"/> Suspected parkinsonism <input type="checkbox"/> With falls	D	
	<input type="checkbox"/> Transient focal neurological symptoms excluding unilateral paresis and speech disorder presenting between 48 hrs. and 14 days	C		Tremor: <input type="checkbox"/> Head <input type="checkbox"/> Upper limbs (bilat.) <input type="checkbox"/> Other movement disorders (Prerequisite: specify the type of movement disorders)	C D E E	
MND	<input type="checkbox"/> Major neurocognitive disorder (MND): (will be seen in neurology, patients with atypical symptoms, rapid progression or those less than 65 year of age with a clinical justification in the "Suspected diagn." section below) (Prerequisite: MMSE result: _____ or MOCA: _____ and attach report) (Recommended: Blood test including B12, TSH, syphilis screening and brain imaging)	D	Epilepsy	<input type="checkbox"/> De novo seizure Known epilepsy without a treating neurologist: <input type="checkbox"/> Controlled/request reevaluation <input type="checkbox"/> Uncontrolled <input type="checkbox"/> Unexplained loss of consciousness	B E C D	
Neuromuscular	Consultation for neuromuscular disease with EMG consideration: <input type="checkbox"/> Carpal tunnel <input type="checkbox"/> Functional impairment at work <input type="checkbox"/> Neuromuscular disorder with atrophy, fasciculations, ↑CK or suspicion of myasthenia <input type="checkbox"/> Polyneuropathy Radiculopathy with a sensory or motor deficit (specify) or isolated mononeuropathy: <input type="checkbox"/> Severe functional impairment (major impact on IADLs and ADLs and symptoms should be present for more than 3 weeks and refractory to conservative treatment) <input type="checkbox"/> Moderate functional impairment (e.g. sleep, work or hobbies) <input type="checkbox"/> Mild and persistent functional impairment	E	Suspected MS	<input type="checkbox"/> Clinical suspicion of MS excluding incidental findings on MRI (Prerequisite: specify symptoms, abnormalities on examination and functional impact in "Suspected diagn." section) Confirmed diagnosis without treating neurologist: <input type="checkbox"/> Active relapse (specify) <input type="checkbox"/> Recent relapse (specify) <input type="checkbox"/> Stable disease (specify)	D B D E	
		D		Headache	<input type="checkbox"/> Migraine (Prerequisite: failed an abortive treatment such as Triptan and 2 prophylactic treatments, history of attempted treatments (agent, dose, effectiveness and duration) (Recommended: specify reason for failure) <input type="checkbox"/> Suspected cluster headache (Horton) (Prerequisite: justify autonomic manifestation) <input type="checkbox"/> Trigeminal neuralgia (Prerequisite: justify paroxysmal pain, facial involvement, trigger zone) (Recommended: attempt treatment with Carbamazepine) <input type="checkbox"/> Other type of headache (Prerequisite: justify suspected diagnosis)	D C C E
		C				
	<input type="checkbox"/> Other reason for consultation or clinical priority modification (MANDATORY justification in the next section):				Clinical priority	
Suspected diagnosis and clinical information (mandatory)					If prerequisite is needed:	
					<input type="checkbox"/> Available in the QHR (DSQ)	
					<input type="checkbox"/> Attached to this form	
Special needs:						
Referring physician identification and point of service					Stamp	
Referring physician's name				Licence no.		
Area code Phone no.		Extension	Area code Fax no.			
Name of point of service						
Signature				Date (year, month, day)		
Family physician: <input type="checkbox"/> Same as referring physician <input type="checkbox"/> Patient with no family physician					Registered referral (if required)	
Family physician's name					If you would like a referral for a particular physician or point of service	
Name of point of service						

Clinical alerts (non-exhaustive list)

Refer the patient to the Emergency-department

- Transient neurological symptoms: lateralized hypoesthesia, monocular blindness, hemianopsia, dysmetria or vertigo with other neurological signs and **excluding** motor or speech disorder for **≤ 48 hrs**
Use the “Accueil clinique” form if available in the area
- Unilateral paresis and/or temporary or fluctuating speech disorder occurring for between **48hrs** and **14 days**
Use the “Accueil clinique” form if available in the area
- Suspected TIA/CVA with unilateral paresis and/or persistent, fluctuating, or temporary speech disorder for < 48 hrs.
- Sudden onset headache or accompanied by warning sign (fever, neurologic deficit, altered sensorium, papilledema, suspected temporal arteritis, etc.)
- Altered state of consciousness or acute confusional state
- Status epilepticus or recurrent seizures
- Suspected rapidly progressing medullary damage
- Suspected Guillain-Barré syndrome

List of diagnoses for which a neurological consultation is not indicated and regional specialised resources are available:

- ADHD
- Isolated vertigo should be referred to ENT
- Isolated low back pain and neck pain (without sign or symptom of radiculopathy)
- Mild TBI and post concussion syndrome
- Sleep disorder