Alberta Health Services

Affix Patient Label within this box

Syncrude Centre for Motion and Balance Referral

Important - Please complete all pages of this form and submit all relevant documentation with this referral. Appointments are made by telephone only, so please include a number where the patient can be reached in the day time.

Send completed referral by **mail** to Syncrude Centre for Motion and Balance Glenrose Rehabilitation Hospital 10230 – 111 Avenue NW, Edmonton, AB T5G 0B7 or **fax** to 780.735.7946. For inquiries **call** 780. 735.8231.

Incomplete information will delay the processing of this referral.

Patient Information

Name *(First, Last)*	Personal Health Number	Date of Birth *(yyyy-Mon-dd)*	Gender ☐ Male ☐ Female
GRH Number	Address		Postal Code
Daytime Phone Number	Alternate Phone Number	Name of Family Contact	

Is this Patient WCB referred? ☐ No ☐ Yes, specify claim Number _____	Name of Other Insurance

Request for Balance Assessment/Treatment *(please check all service(s) required and attach all relevant documentation)*

☐ Videonystagmography *[audiology/VNG]*

☐ Vestibular Clinic *[interdisciplinary (neurotology, neurology, physiatry, audiology, physical therapy), tertiary assessment and management of clients with complex peripheral and central vestibular disorders; referrals will be considered from Otolaryngologists, Neurologists and Glenrose Physiatrists. Family physicians should refer to these specialists]*

☐ Posturography *[computerized dynamic posturography assessment to quantify sensory and motor functional impairments when additional information is required to supplement clinical examination and VNG; referrals by specialists as listed above]*

☐ Vestibular Rehabilitation *[specialized physical therapy assessment and intervention for clients with confirmed peripheral and central vestibular disorders supported by objective findings of clinical exam and/or VNG testing]*

Request for Motion Assessment *(please check all services required)*

	Walking Aid: With / Without
☐ Video record of movement only *(standard definition coronal/sagittal)*	_____/_____
☐ High Speed Video	_____/_____
☐ Instrumented Gait Analysis *(Spatiotemporal, Kinematics, Kinetics if possible)*	_____/_____
☐ Electromyography *(EMG)*	_____/_____
☐ Pedobarograph	_____/_____

What is the specific clinical question you would like answered and how will this assessment contribute to the management of this patient?

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Investigations *(Please attach copies of completed investigations)*

CT	☐ No ☐ Yes	Audiology	☐ No ☐ Yes	Previous motion analysis	☐ No ☐ Yes
MRI	☐ No ☐ Yes	Posturography	☐ No ☐ Yes	Videonystagmography	☐ No ☐ Yes

Other Investigations

History and Physical Findings *(Please attach copies of relevant specialist consult reports including those of referring physician)*

Relevant Medical History

Past and Current Medications

Physical Findings

Relevant Past Treatments

Send additional copy of report to *(please print the Physician(s) name and address below)*:

Referring Physician Name	Signature		Date *(yyyy-Mon-dd)*
Address	Postal Code	Phone	Fax