

Hydrocephalus Referral

For more information on clinic locations, and where to send the referral visit: www.albertareferraldirectory.ca and use keyword search “hydrocephalus”

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
PHN	ULI <input type="checkbox"/> Same as PHN	MRN	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

- This referral is to evaluate patients with hydrocephalus (*enlarged ventricles*), typically, but not always, with one or more of the primary symptoms, including: gait/balance issues, bladder/bowel issues, or cognitive decline.
- Many elderly patients with large ventricles do not always have hydrocephalus as this condition requires a clinical diagnosis.
- **CT and/or MRI Imaging within last 12-24 months is a prerequisite to the referral.**
- Please complete this form as accurately as possible, to allow our clinic to triage efficiently.

Additional Patient Information

Patient/Caregiver Name	Phone
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Referring Physician

Name		Phone
Address	City	Fax
Email		

Medical History

Significant Medical Conditions (*heart, respiratory, cerebrovascular diseases, etc.*)

Allergies

Medications

 (*choose all that apply*)

- ASA
 Clopidogrel (*Plavix*)
 Ticagrelor (*Brilinta*)
 Warfarin
- Other anticoagulants (*specify*) _____
- If on anticoagulants, provide details _____

Imaging (CT and/or MRI) - it is required that patient has had brain imaging within 12-24 months (*provide details below*)

Type of Imaging _____

Date completed (*dd-Mon-yyyy*) _____

Relevant report attached

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Previous Treatment Assessments

- Does the patient have VP or other type of shunt? No Yes *(if yes, specify year inserted)* _____
- Had an endoscopic third ventriculostomy? No Yes *(if yes, specify year)* _____
- Ever had testing with a large volume tap *(lumbar puncture)*? No Yes
- Ever had testing with an external/extended lumbar drain? No Yes

Hydrocephalus Relevant Clinical Information

Gait

- Walking issues *(i.e. takes time to start walking, speed declined)* No Yes
- Balance issues *(i.e. worried about falling)* No Yes
- Any recent falls No Yes *(if yes, specify # of times in past year)* _____
- Gait aids required *(i.e. walker, cane)* No Yes
- Duration of gait abnormality Less than 2 years 2-5 years More than 5 years

Cognition

- Memory issues *(i.e. have to make lists/write things down more often)* No Yes
- Prior testing for cognitive function No Yes
(if yes, specify test types and when tested) _____
- Concentration issues *(i.e. they/family notice they miss parts of conversations)* No Yes
- Sleeping more than usual No Yes
- Duration of cognitive abnormality Less than 2 years 2-5 years More than 5 years

Bladder/Bowel Issues *(choose all that apply)*

- Frequency Urgency Nocturia Incontinence

Neurological Medical History *(choose all that apply)*

- Congenital hydrocephalus
- Cancer
- Traumatic brain injury
- Intracranial neurosurgical procedures *(including ventriculostomy)*
- Intraventricular hemorrhage
- Subarachnoid hemorrhage
- Brain tumor
- Meningitis
- Spinal disease/surgery