Confidential. Please discard if received in error.

Sparrow Neuropsychology – Referral Form

Thank you for your referral! Referrals can be sent via:

Fax: **(236) 259 5318**

Secure email: **referrals@sparrow.clinic** *To encrypt emails automatically, please send from a free protonmail.com account. Referrals cannot be accepted from non-encrypted addresses (cf. BC privacy law).*

Phone: **(236) 501 5099**

From Referring Clinician: _____

Clinic / Practice Name: _____

Clinic phone: _____

Signature: _____

Patient name: _____

Date of Birth: _____ **Phone:** _____

Patient email: _____

Primary language(s) spoken: _____

Consent to be contacted directly by Sparrow Neuropsychology? ☐ Yes ☐ No

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So we can help, please include the below or a consult note with relevant detail. Thank you!

Reason for Referral

☐ Memory concerns

☐ Concussion / head injury

☐ Stroke

☐ Multiple sclerosis (MS)

☐ Epilepsy / seizure disorder

☐ Brain tumor

☐ ADHD / attention difficulties

☐ Learning concerns

☐ Functional assessment (e.g., return to work/school)

☐ Other: _____

Specific Referral Question. What question should the assessment answer?

Supporting Documentation (please attach if available):

- Recent consultation notes (neurology, GP, emergency dept or rehab…)
- Brain imaging reports (e.g., MRI, CT, EEG)
- Psychological/psychiatric
- Medication list
- Please note any other relevant history:

Thank you! Referrals can be sent by (1) fax, (2) encrypted email (above), or (3) phone.