HEURO
ASSESS. TRANSFORM. MAXIMIZE.

Date of Referral (DD/MM/YYYY):

Referring Clinician Information

Physician Name: _____

Phone Number (XXX-XXX-XXXX): _____

Fax Number (XXX-XXX-XXXX): _____

Patient Information

Patient Name: _____

Date of Birth (DD/MMM/YYYY): _____

Healthcare Number/PHN: _____

Phone Number (XXX-XXX-XXXX): _____

E-mail: _____

Comments:

Physician Confirms (tick each box and sign)

I have read and understand the Health Canada recommendations for PoNS™ treatment ☐

I confirm this treatment program is safe and suitable for my patient ☐

Referring Clinician Signature: _____

Signature Date (DD/MMM/YYYY): _____