MINDS
Mississauga Institute of Neurological Disorders and Stroke

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TREATMENT REQUISITION FORM

PATIENT INFORMATION		
Last Name:	First Name:	Gender: ☐ Male ☐ Female
Date of Birth (DD/MM/YYYY):	Home #:	Cell #:
Health Card #:	☐ OHIP ☐ Private Pay ☐ Motor Vehicle Accident ☐ Private Medical Insurance	

TREATMENTS	INDICATIONS
☐ BOTOX for Movement disorders and Spasticity	☐ Dystonia ☐ Spasticity ☐ Sialorrhea ☐ Hemifacial Spasm ☐ Post-stroke rehabilitation ☐ Others: _____
☐ **TMS (Transcranial Magnetic Stimulation)***	☐ Depression (level A) ☐ mTBI/PCS depression (level A) ☐ Post-stroke rehabilitation upper extremity (Level A) ☐ Neuropathic Pain (Level A) ☐ Post stroke Aphasia (level B) ☐ Refractory tinnitus (level C) ☐ Refractory tinnitus (Level C)
☐ **BOTOX (Migraine)***	☐ Chronic migraine ☐ Chronic post-concussive headache
☐ **Median Nerve Hydro-dissection for Carpal Tunnel syndrome ***	☐ Carpal tunnel prp/Median Nerve Hydro-dissection(carpal tunnel syndrome) ☐ Platelet-rich plasma for diabetic neuropathic pain*

***not covered by OHIP**

REFERRING PHYSICIAN INFORMATION	
Name:	Billing Number:
Phone:	Fax:
Copies to:	