National Neuroscience Institute
SingHealth

REFERRAL TO NNI SPECIALISTS OUTPATIENT CLINICS

National Neuroscience Institute (Tan Tock Seng Hospital Campus)
Level 1, 11 Jalan Tan Tock Seng, Singapore 308433
6357-7095 (Appointment Line) 6357-7088 (General Enquiries)
da_neuroscience@nni.com.sg (Email)

For Appointments, please fax the referral form to 6357-7103.
For Urgent Cases and Direct Access, please call us at 9637-9718.

Patient's Name: ______________________ NRIC/Passport No: ______________

Home/Mobile/Office Nos: ______________________ Date of Birth: ______________

Address: ____

Please SELECT ONLY ONE OPTION [examples of conditions in brackets]

☐ **Named Referral:**

☐ **General Neurology**
☐ **Botulinum Toxin Injections (Botox)**
☐ **Epilepsy** [fits, funny turns, blank stares]
☐ **Headaches & Migraine**
☐ **Neuro-immunology/Neuro-infectious Disease**
☐ **Paediatric Epilepsy**
☐ **Sleep Disorders** [snoring, excessive sleepiness]
☐ **Alzheimer's Disease & Dementia**
☐ **Neuromuscular Diseases** [neuropathies, myopathies, myasthenia gravis, motor neuron disease, muscular dystrophy]
☐ **Parkinson's Disease & Movement Disorders** [parkinsonism, tremors, hemifacial spasm, dystonia, tics]
☐ **Stroke** [transient ischaemic attacks, vertebrobasilar insufficiency]

☐ **General Neurosurgery**
☐ **Brain Tumours**
☐ **Head Injury**
☐ **Hyperhidrosis** [sweaty palms, sweaty armpits]
☐ **Paediatric Neurosurgery**
☐ **Pituitary Tumour**
☐ **Skull Base Neurosurgery**
☐ **Stereotactic Radiosurgery & Radiotherapy**
☐ **Endoscopic Neurosurgery**
☐ **Functional Neurosurgery** [parkinson disease, epilepsy surgery]
☐ **Neuro-oncology**
☐ **Neuro-vascular Neurosurgery** [cerebral aneurysm, arteriovenous malformation, carotid endarterectomy]
☐ **Peripheral Nerve Surgery** [carpal tunnel syndrome, ulnar nerve etc.]
☐ **Spinal Injury & Spine Surgery** [including neck pain, back pain, cervical myelopathy, P.I.D.]

Kindly include History, Physical Findings and Reason for Referral

Referring Doctor: ______________ **Clinic Name:** ______________

MCR No.: ______________ Clinic Assistant: ______________

Signature ______________ Telephone & Fax: ______________

For NNI's use only

Thank you for referring to Neuroscience Clinics, your patient's appointment is confirmed as indicated below.

Appt Date & Time: ______________________ Doctor: ______________

Consultation Charges: ______________ *(Excludes charges for medication, investigations, procedures)*

Referral is valid for 6 months from date of referral letter. Please remind patient to bring referral letter & identification card.

Revised Date: 08 April 2010