



ATC AAC CLINIC  
Baycrest Brain Health Centre  
Telephone: (416) 784-3600 Fax: (416) 784-5600

## REQUEST FOR CONSULTATION

PATIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

TELEPHONE: RES: ( ) \_\_\_\_\_

BUS: ( ) \_\_\_\_\_

C.P.: ( ) \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Day

Month

Year

HEALTH CARD: \_\_\_\_\_

FAMILY DR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**\*PLEASE INCLUDE ANY TEST RESULTS & CURRENT DOCTOR'S NOTES\***

REFERRING DR.: \_\_\_\_\_ BILLING # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

TELEPHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

**MEDICATION LIST:**

**REASON FOR REFERRAL:** Reasons for referral: Services of the AAC Team - Technology Assessment  
(e.g. Augmentative and Alternative Communication, Environmental Aids for Daily Living, Mobility Aids)

**DIAGNOSIS:**

SIGNATURE: \_\_\_\_\_

DATE \_\_\_\_\_

Please Fax your referral to (416) 784-5600

IMPORTANT NOTICE ON CONFIDENTIALITY:

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