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