REGIONAL STROKE TEAM,
NORTH AND EAST GTA
Sunnybrook Health Sciences Centre
Assistive Technology Clinic, Rm. UG20,
2075 Bayview Avenue, Toronto, ON M4N 3M5
Telephone: (416) 480-6100 x 3966   Fax: (416) 484-0872

REQUEST FOR CONSULTATION

Patient Name: ____
Address: ____
____
Telephone: ______________ / ______________ / ______________
home **cell** **work**
Date of Birth: ______________________ **Gender**: M / F
Health Card Number: ____
Contact Name: ____
Contact Number: ______________ / ______________ / ______________
home **cell** **work**
Diagnosis and Location of Stroke: ____
____

PLEASE INCLUDE ALL MEDICAL AND REHAB REPORTS

Reason for Referral: ☐ **Urgent** ☐ **Non-Urgent**

- Occupational Therapy
- Physiotherapy
- Speech-Language Pathology
  - ☐ Swallowing
  - ☐ Communication
- Spasticity Clinic

Has patient received Stroke Passport? Yes / No

Signature: ______________________ **Date:** ______________________

Referring Doctor: ______________________ **Phone number:** ______________
(PRINT)

Please fax your referral to (416) 484-0872

IMPORTANT NOTICE ON CONFIDENTIALITY:
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