SEATING/WALKER
Baycrest – Brain Health Centre
3560 Bathurst St., Main Floor, Toronto, ON M6A 2E1
Telephone: (416) 784-3600 Fax:(416) 784-5600

REQUEST FOR CONSULTATION

PATIENT NAME: _____
ADDRESS: _____
_____
_____

TELEPHONE: **RES: ( )** _____
BUS: ( ) _____

DATE OF BIRTH: _____
Day Month Year

HEALTH CARD: _____

DIAGNOSIS: _____

FAMILY DOCTOR: _____ **ADDRESS:** _____

DOCTOR PHONE #: _____ **DOCTOR FAX #:** _____

Please check if any of these apply:		ODSP ☐ WSIB ☐ Veterans Affairs ☐ MVA ☐
Then include relevant information:		**Case/Claim/ODSP #:**
Additional report(s) included : **Yes No**		**Contact/Case manager:**
# of pages	_____	**ODSP OFFICE:**
CLIENT PREFERRED VENDOR: (optional)		

(Shoppers, Motion Specialties, HME, etc)

RELEVANT MEDICAL AND REHABILITATION HISTORY (E.G. MEDICATIONS, INVESTIGATIONS)

REASON FOR REFERRAL:
Patient requires new Seating/Wheelchair /Scooter/Walker due to: (Examples: Mobility impairment (specify); requires replacement device; skin issues/pressure sores (specify); postural issues (specify); etc.)

SIGNATURE: _____ **DATE** _____

Please Fax your referral to the appropriate site above.