

SEATING/WALKER

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

REQUEST FOR CONSULTATION

PATIENT NAME: ADDRESS:					
TELEPHONE:	RES: ()_ BUS: ()_				
DATE OF BIRTH:					
HEALTH CARD:	Day		Month	Year	
DIAGNOSIS:					
FAMILY DOCTOR	:		ADDRESS:		
DOCTOR PHONE	#:		DOCTOR FA	X #:	
Please check if any of these appli	ly:	ODSP 🗆	WSIB 🗆	Veterans Affairs □	MVA [
Then include relevant information	on:	Case/Claim/OD	SP #:		
Additional report(s) included	: Yes No	Contact/Case m	anager:		
# of pages		ODSP OFFICE	<u>:</u>		
CLIENT PREFERRE	D VENDOR: (c	optional)			
RELEVANT MEDI	CAL AND REI	HABILITATI		<u> Iotion Specialties, HME, etc)</u> E.G. MEDICATIONS, INVES	STIGATIONS)
REASON FOR REF Patient requires new Seating device; skin issues/pressure s	ERRAL: /Wheelchair /Scooter	/Walker due to: (Ex	camples: Mobility impa		
SIGNATURE:	DATE				
Please Fax your refe	rral to the annr	onriate site abo	IVe.		

IMPORTANT NOTICE ON CONFIDENTIALITY:

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