Spasticity Clinic

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: ( ) _____
C.P.: ( ) _____

DATE OF BIRTH: _____
Day **Month** **Year**

HEALTH CARD: _____ **GENDER** M / F

FAMILY DR: _____
ADDRESS: _____
_____

TELEPHONE: **( )** _____ **FAX: ( )** _____

REFERRING DR.: _____ **BILLING #** _____
ADDRESS: _____
_____
_____

TELEPHONE: **( )** _____ **FAX: ( )** _____

DIAGNOSIS:

REASON FOR REFERRAL:
Reasons for referral: *(example:* Spasticity interferes with Activities of Daily Living; is causing skin ulceration due to problems with seating/positioning etc.)

CURRENT MEDICATIONS:

SIGNATURE:_____ **DATE:**_____

Please Fax your referral to the appropriate site above.