



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.

IMPORTANT NOTICE ON CONFIDENTIALITY:

Thank you for your referral to the ATC Spasticity Clinic. The contents of this fax transmission contain confidential information intended for the person(s) named above. Any copying, disclosure or distribution is strictly prohibited. In the event that this fax was received in error, please notify us immediately by phone and destroy this document.