ASSISTIVE TECHNOLOGY CLINIC

Upper Extremity Program
3560 Bathurst St., Main Floor,Toronto, ON M6A 2E1
Telephone: (416) 784-3600 Fax: (416) 784-5600

REQUEST FOR CONSULTATION

PATIENT NAME: _____

HEALTH CARD: _____ **DATE OF BIRTH:** _____ (DD/MM/YYYY)

PHONE: _____ **WORK/CELL:** _____

ADDRESS: _____

DIAGNOSIS: _____

REFERRAL SOURCE: _____ **FACILITY/COMPANY:** _____

ADDRESS: _____

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

Please check if any of these apply:	Private Insurance ☐ WSIB ☐ Veterans Affairs ☐ MVA ☐
Then include relevant information:	**Case/Claim #:**
Additional report(s) included ☐ _____ pages	**Contact/Case manager:**

Inclusion criteria for Upper Extremity Program:

- **Has some minimal hand/wrist movement**
- **Able to attend 3 times/week**
- **Able to do homework**
- **Able to co-pay for a monthly rehabilitation program**
- **Able to follow instructions and learn new skills**

Reason for referral & Clinical notes: _____

Current Medications: _____

Special approval for Ness H200 Device required by Physician if patient has (please check):				
history of seizures___	*baclofen pump __*	*metallic implants__*	**atrial fibrillation__*	**Arterial/Venous Occlusion __*
** Indicates the need for ATC to contact your Cardiologist:*	*Cardiologist::*		*Contact #:* ( ) - - .	

SIGNATURE: _____ **DATE:** _____

Please Fax your referral to the appropriate site above.

IMPORTANT NOTICE ON CONFIDENTIALITY:

Thank you for your referral to the ATC. 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.

Leaders in Innovative Rehabilitation

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