



Augmentative and Alternative Communication
 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: _____
 PRIMARY CONTACT: _____ PHONE: _____

<i>Please check if any of these apply:</i>	Private Insurance <input type="checkbox"/>	ODSP <input type="checkbox"/>	WSIB <input type="checkbox"/>	Veterans Affairs <input type="checkbox"/>	MVA <input type="checkbox"/>
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REFERRING DR.: _____	BILLING # _____
ADDRESS: _____	
TELEPHONE: () _____	FAX: () _____

DIAGNOSIS: Stroke MS Movement Disorder ALS Other: _____

PROGRAM REQUESTED:
 Speech Writing Technology

REASON FOR REFERRAL: _____

SIGNIFICANT MEDICAL HISTORY (specify) _____

****Please attach most recent medical report****

CURRENT MEDICATIONS: _____

SIGNATURE: _____ DATE: _____

Please Fax your referral and most recent medical report.

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.