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:** _____

Please check if any of these apply:	**Private Insurance** ☐	**ODSP** ☐	**WSIB** ☐	**Veterans Affairs** ☐	**MVA** ☐

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:

Leaders in Innovative Rehabilitation

www.assistivetechnologyclinic.ca