Occupational Therapy
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:

☐ **Seating & Mobility** ☐ **Augmentative & Alternative Communication**
☐ **Assistive devices** ☐ **Splints** ☐ **Environmental Aids for Daily Living (EADL)**

**For Environmental Aids for Daily Living EADL, please download the specific referral form. **

REASON FOR REFERRAL: ____________________

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SIGNIFICANT MEDICAL HISTORY (specify) ____________________

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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.

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