ATC ASSISTIVE TECHNOLOGY CLINIC

ELKIE ADLER MULTIPLE SCLEROSIS CLINIC

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Baycrest

REQUEST FOR REHABILITATION/ALLIED HEALTH CONSULTATION

PATIENT NAME: _____

ADDRESS: _____

_____

TELEPHONE: RESIDENCE: ( ) _____ BUS : ( ) _____

ALTERNATE CONTACT:

NAME: _____ PHONE: ( ) _____

PHONE: ( ) _____ PHONE: ( ) _____

RELATIONSHIP: _____

HEALTH CARD: _____ GENDER: M/F

DATE OF BIRTH: _____
Day Month Year

FAMILY DR: _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

REFERRING DR.: _____ BILLING # _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

DIAGNOSIS: _____

PLEASE INCLUDE ALL MEDICAL AND REHAB REPORTS

Reason for Referral: _____

_____

_____

Please check services required:

o **Neurology** o **Physiatry**	o Physiotherapy o Occupational Therapy	o Speech-Language Pathology ❑ Swallowing ❑ Communication

SIGNATURE: _____ **DATE:** _____

Leaders in Innovative Rehabilitation

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