ATC SPASTICITY MANAGEMENT CLINIC
3560 Bathurst Street, Main Floor, Elkie Adler Wing, Toronto, Ontario M6A 2E1 Tel: (416) 784-3600 Fax: (416) 784-5600

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 if any apply:

☐ **Interferes with daily living:** • **Walking** • **Dressing** • **Personal Hygiene**	☐ **Skin ulceration** ☐ **Positioning or seating** ☐ **Nursing Care**	☐ **Speech** ☐ **Swallowing**

SIGNATURE: _____ **DATE:** _____

Leaders in Innovative Rehabilitation
www.assistivetechnologyclinic.ca