Speech Language Pathology
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 ☐ Other: ____________________

PROGRAM REQUESTED:

☐ **Communication Strategies** ☐ **Augmentative & Alternative Communication**
☐ **Voice Program** ☐ **Memory and Language Program** ☐ **Swallowing**

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:
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