BAYCREST SITE
3560 BATHURST STREET,
Kimel Family Building,
Toronto, ON M6A 2E1
Tel: 416.784.3600

ATC
Assistive Technology Clinic

SUNNYBROOK SITE
2075 BAYVIEW AVENUE,
Rm. UG20 SCIL,
Toronto, ON M4N 3M5
Tel: 416.480.5756

REFERRAL FORM

Please fax the completed form to 416 784 5600

PATIENT INFORMATION

Last Name: _____ First Name: _____

Health Card #: _____ Ver.: _____ Expiry Date: _____/__/___ (YYYY/MM/DD) Date-of-Birth: _____/__/___ (YYYY/MM/DD)

Address: _____ City: _____ Postal Code: _____ Phone: _____

PRIMARY CONTACT (if different from patient)

Full Name: _____

Phone: _____

Relationship to Patient: _____

FUNDING SOURCE

- ☐ ODSP
- ☐ Private Insurer
- ☐ WSIB
- ☐ Interim Federal Health Grant
- ☐ Veteran
- ☐ Self-Pay
- ☐ Auto Insurance

Case/Claim #: _____

Insurance Company (if applicable): _____

Case Worker/Adjuster's Name: _____

Telephone #: _____ Fax#: _____

MEDICAL INFORMATION

Primary Diagnosis: _____

Other Diagnosis: _____

Medications: _____

_____

_____

The patient currently has the following communicable disease(s):

- ☐ MRSA
- ☐ VRE
- ☐ C-Difficile
- ☐ Other: _____

☐ Consult Notes Included

Reason for Referral:

_____

_____

_____

_____

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PHYSICIAN REFERRAL REQUIRED FOR THE CLINICS LISTED BELOW

Please Include All Relevant Medical And Rehabilitation Reports

☐ **ALS Clinic**	☐ Occupational Therapy ☐ Speech-Language Pathology ☐ Dietitian
☐ **MS Clinic** MS Type: _____	☐ Neurology Consult ☐ Physiatry Consult ☐ Occupational Therapy ☐ Physiotherapy ☐ Dietitian ☐ Speech-Language Pathology
☐ **Parkinson's & Movement Disorders Clinic**	☐ Neurology Consult ☐ Occupational Therapy ☐ Physiotherapy ☐ Dietitian ☐ Speech-Language Pathology ☐ Pharmacist ☐ Counselling ☐ Driving Screen
☐ **Stroke Clinic**	☐ Occupational Therapy ☐ Physiotherapy ☐ Speech-Language Pathology ☐ Driving Screen
☐ **Spasticity Clinic**	Reason for referral: _____ _____ _____

HEALTHCARE PROVIDER REFERRAL REQUIRED FOR THE CLINICS LISTED BELOW

Please Include All Relevant Medical And Rehabilitation Reports

☐ **Augmentative & Alternative Communication Clinic (AAC)**	☐ Speech Generating Devices ☐ Writing Aids ☐ Computer Access
☐ **Speech/ Language Programs**	☐ Cognitive Communication ☐ Communication Strategies Training ☐ Voice Program ☐ Swallowing Examination
☐ **Environmental Aids for Daily Living (EADL) Program**	☐ Television ☐ Lights ☐ Telephone ☐ Other: _____
☐ **Seating & Mobility Clinic**	☐ Manual Wheelchair ☐ Power Wheelchair ☐ Custom Seating ☐ Walker ☐ Scooter ☐ Other: _____ Preferred Vendor:
☐ **Neuro-rehabilitation** (physiotherapy and occupational therapy)	☐ Gait Robotics Program ☐ Gait and balance Training ☐ Upper Extremity Program ☐ Splinting ☐ Other: _____

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REFERRING HEALTHCARE PROFESSIONAL

☐ OT
☐ PT
☐ SLP
☐ Physician
☐ Nurse
☐ Practitioner
☐ Other: _____

Full name: _____

Address: _____

Clinic: _____ Billing #: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

FAMILY PHYSICIAN INFORMATION ☐ Same as above

Full name: _____ Address: _____

Clinic: _____ Billing #: _____

Phone: _____ Fax: _____

Medical/Rehab History & Referral Notes:

_____

_____

_____

_____

_____

_____