ATC
Assistive Technology Clinic

REFERRAL FORM

Please fax the completed form to 416 784 5600

PHYSICIAN REFERRAL REQUIRED FOR THE CLINICS LISTED BELOW

Please Include All Relevant Medical And Rehabilitation Reports

MS Clinic
MS Type: _____

- ☐ Neurology Consult
- ☐ Pharmacist

Parkinson's & Movement Disorders Clinic

- ☐ Neurology Consult
- ☐ Pharmacist

Spasticity Clinic

Reason for referral:

_____

_____

_____

HEALTHCARE PROVIDER REFERRAL REQUIRED FOR THE CLINICS LISTED BELOW

Please Include All Relevant Medical And Rehabilitation Reports

Speech/ Language Programs

- ☐ Communication Strategies Training
- ☐ Swallowing Examination

Neuro-Rehabilitation (physiotherapy and occupational therapy)

- ☐ Gait and balance Training
- ☐ Upper Extremity Program
- ☐ Other: _____

Baycrest Health Sciences
3560 Bathurst St, Kimel Family Building, Toronto, ON M6A 2E1
Tel: 416.784.3600 | Fax: 416.784.5600

ATC
Assistive Technology Clinic

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:

_____

_____

_____

_____

Baycrest Health Sciences
3560 Bathurst St, Kimel Family Building, Toronto, ON M6A 2E1
Tel: 416.784.3600 | Fax: 416.784.5600

ATC
Assistive Technology Clinic

REFERRAL FORM

Please fax the completed form to 416 784 5600

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:

_____

_____

_____

_____

_____

_____

Baycrest Health Sciences
3560 Bathurst St, Kimel Family Building, Toronto, ON M6A 2E1
Tel: 416.784.3600 | Fax: 416.784.5600