



Coordinated Care for People with Epilepsy

clinictocommunity.ca
info@clinictocommunity.ca

Pediatric Neurology Referral Form

Please fill out and return to Epilepsy Support Centre:

E-mail: info@clinictocommunity.ca
Phone (519-433-4073) Fax (519-433-4079)
Mail (690 Hale St. London, ON N5W 1H4).

Date: _____ Guardian Name: _____

Name: _____ Date of Birth: _____

Address: _____

City: _____ Postal Code: _____ E-mail: _____

Phone: _____ Seizure Type(s): _____

Reason For Referral (check all that apply):

New Diagnosis/ Coping Strategies

School/ Workplace Support

Seizure Education/ First Aid Training

Children's Programming

Parent and/ Family Support

Other _____

Referral Made By: _____ Neurologist: _____

Phone: _____ Fax: _____

Consent to Contact (client/ guardian signature): _____

