Clinic To Community

Coordinated Care for People with Epilepsy

clinictocommunity.ca
info@clinictocommunity.ca

Paediatric Neurology Referral Form

Please fill out and return to Epilepsy Southwestern Ontario:

E-mail: info@clinictocommunity.ca

Phone (519-433-4073) Fax (519-433-4079)

Mail (797 York St., Unit 3 London, ON, N6H 4V3)

Referral 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
- ☐ Chidren's Programming
- ☐ Parent and Family Support
- ☐ Other _____

Referral Made By: _____ Neurologist: _____

Phone: _____ Fax: _____

Consent to Contact (client / guardian signature): _____

epilepsy southwestern ontario

ONTARIO BRAIN INSTITUTE

Ontario Trillium Foundation

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