Coordinated Care for People with Epilepsy

clinictocommunity.ca
info@clinictocommunity.ca

Adult 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 N5W 6A8).

Referral Date: ______________________________

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
- ☐ Seizure Education / First Aid Training
- ☐ Parent and Family Support
- ☐ Other ______________________________
- ☐ School/ Workplace Support
- ☐ Volunteering / Social Programs

Referral Made By: ______________________ Neurologist: ______________________

Phone: ______________________ Fax: ______________________

Consent to Contact (client / guardian signature): ______________________