



## 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, Ontario 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):

- |   |   |
|---|---|
| <input type="checkbox"/> New Diagnosis / Coping Strategies      | <input type="checkbox"/> School/ Workplace Support      |
| <input type="checkbox"/> Seizure Education / First Aid Training | <input type="checkbox"/> Volunteering / Social Programs |
| <input type="checkbox"/> Parent and Family Support              |   |
| <input type="checkbox"/> Other _____                            |   |

Referral Made By: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Consent to Contact (client / guardian signature): \_\_\_\_\_