Coordinated Care for People with Epilepsy

clinictocommunity.ca

Referral Form

Please fill out and return to Epilepsy Ottawa

E-mail: c2c@epilepsyottawa.ca

Phone (613-594-9255) Fax (613-594-5189)

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

☐ School/ Workplace Support

☐ Volunteering / Social Programs

☐ UPLIFT (Depression/Anxiety)

☐ Other _____

Referral Made By: _____

Phone: _____ Fax: _____

Consent to Contact (client / guardian signature): _____

☐ Consent provided verbally

Partner Agency: epilepsy ottawa | ottawa épilepsie

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