Epilepsy Toronto Referral Form

EPILEPSY Toronto
See the Person

Please download this PDF to your computer before completing it.

Referred by: _____ Date: _____
(Staff/Volunteer Name)

Organization / Agency /Clinic: _____ Phone: _____

Client Information

Name: _____ ☐Infant ☐Child ☐Youth ☐Adult ☐Senior

If person with seizures requires guardian or parent as primary contact:

Contact Name: _____ Relationship to client: _____

Phone 1: _____ Can we leave a message? ☐Yes ☐No

Phone 2: _____ City of residence: _____

E-mail Address: _____

Preferred method of contact: ☐Phone 1 ☐Phone 2 ☐Email

Type of Service Requested:

_____

_____

Notes:

_____

_____

I, _____ give _____ permission to contact me about these services
(Patient/Guardian Name) (Epilepsy Agency Name)

Signature: _____ **OR** ☐Verbal consent over the phone

Please email this form back to info@epilepsytoronto.org, fax through to 416-964-2492, or click on the submit button below.

Submit