

Referral Form

Please fill out and return to Epilepsy South Central Ontario:

E-mail: c2c@epilepsysco.org

Phone (905-450-1900) Fax (905-820-9393)

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): _____