Coordinated Care for People with Epilepsy

clinictocommunity.ca
c2c@epilepsyottawa.ca

Paediatric Neurology 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: _____ Guardian Name: _____

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
- ☐ Youth Programming
- ☐ UPLIFT (depression, anxiety)

Language Preference:

- ☐ English Preferred
- ☐ French Preferred
- ☐ French Exclusively

Referral Made By: _____ Neurologist: _____

Phone: _____ Fax: _____

Consent to Contact (client / guardian signature): _____

☐ Consent provided verbally

Partner Agency : epilepsy ottawa | ottawa épilepsie

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