Clinic To Community

Coordinated Care for People with Epilepsy

clinictocommunity.ca

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):

- ☐ New Diagnosis / Coping Strategies
- ☐ School/ Workplace Support
- ☐ Seizure Education / First Aid Training
- ☐ Volunteering / Social Programs
- ☐ Parent and Family Support
- ☐ Other _____

Referral Made By: _____

Phone: _____ Fax: _____

Consent to Contact (client / guardian signature): _____

epilepsy south central ontario

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