SOUTHERN ONTARIO
EPILEPSY CLINIC
IMPROVING CARE THROUGH EDUCATION

For office use only

General Epilepsy Referral Form

Thank you for choosing Southern Ontario Epilepsy Clinic. To best serve you within a reasonable time frame please have this form filled out completely and legibly. Please send the necessary information along with the referral so that it can be appropriately triaged by. Dr. Bercovici.

PLEASE FAX COMPLETED REFERRAL FORM TO **416-620-7633**

Patient Information

Name: ____ DOB: ___________________________

Health card number: ____________________________ Version Code: ___________________

Address: _______________________________________ City: ____________________________

Telephone #: Mobile: (_____)_______________ Home/Business: (_____)__________

Reason for Referral

( ) First seizure

( ) 2nd opinion / consultation only

( ) medically refractory epilepsy (failed > 2 antiepileptic medications)

( ) Transition of care from paediatrics

Type of referral

( ) Consultation and video EEG

( ) Consultation only

Medications: ____

Past Medical history ____

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Referring Physician information

Name: _______________________________________ (MD / NP) Billing # __________________

Address: ____

Telephone # _________________________ Fax # ___________________________

Signature: _______________________________________