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 _____

_____

Referring Physician information

Name: _____ (MD / NP) Billing # _____

Address: _____

Telephone # _____ Fax # _____

Signiature: _____

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