
# Coordinated Care for People with Epilepsy

clinictocommunity.ca

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: 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 [ ]  UPLIFT (Depression/Anxiety)

[ ]  Other

Referral Made By:

Phone: Fax:

Consent to Contact (client / guardian signature):

[ ]  Consent provided verbally