

# Coordinated Care for People with Epilepsy

clinictocommunity.ca

Referral Form

Please fill out and return to Epilepsy Ottawa E-mail: [c2c@epilepsyottawa.ca](mailto: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