Outpatient Transitional and Lifelong Care (TLC) Program Referral

Parkwood Institute Main Building
550 Wellington Rd. London, ON. N6C 0A7
Phone: 519-685-4292 x 42669
Fax: 519-685-4075

DATE OF REFERRAL:_____

Patient Name:	Referring Physician:
DOB (YY/MM/DD):	Phone:
OHIP #:	Fax:
Contact phone:	Billing Number:
Address:	Physician's Signature:

Reason for Referral (include relevant history, planned follow up, suggested long term monitoring)

☐ Condition and age of onset:

☐ Ambulatory status:

☐ Associated features (check all that apply):

☐ Seizure disorder ☐ Stable ☐ Unstable ☐ Followed by:_____ ☐ Hydrocephalus ☐ Shunted (type:_____) ☐ Most recent revision: _____ ☐ Cognitive disorder ☐ Pain ☐ Spasticity ☐ Mood disorder ☐ Behavioural issues	☐ Bladder dysfunction ☐ Renal anomalies ☐ Bowel dysfunction ☐ Dysphagia/feeding issues ☐ Enteral feeding ☐ Endocrine abnormalities ☐ Orthopedic (scoliosis, hip dislocation, etc) ☐ Osteoporosis ☐ Skin breakdown ☐ Other: _____ _____

☐ Surgeries related to condition (please list):

PLEASE ATTACH: Any relevant MRI / CT Reports, X-Rays, Bloodwork, consult reports

Please circle urgency of request.

(non-urgent) **0** **1** **2** **3** **4** **5** (very urgent)

Please fax completed form to 519-685-4075

Questions (519) 685-4292 x 42669

☐ Referral declined, not appropriate for this clinic.