Outpatient Transitional and Lifelong Care (TLC) Program Referral

Parkwood Institute
500 Wellington Rd. London, On. N6C 0A7
Phone: 519-685-4292 X 44579
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 (incl relevant history, planned follow up, suggested long term monitoring)

- ☐ Condition and age of onset:
- ☐ Ambulatory status:
- ☐ Associated features (check all that apply):

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

- ☐ 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 44579

☐ Referral declined, not appropriate for this clinic.