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| **MEDICAL INFORMATION** | | | |
| Current Diagnoses: | | | |
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| Pertinent History (surgery, etc.) | | | |
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| Current Medications and other treatments: | | | |
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| □ Please explain current areas of concern: | | | |
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| Physician |  | Phone  Fax |  |
| Address: | | □ Yes, the physician is aware of this referral? | |

|  |
| --- |
| **Involvement of other specialized services :** |
| □ Speech and Language Pathologist □ current □ year discharged: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Behavioural Consultant □ current □ year discharged: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Dietician: □ current □ year discharged:: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other: |

I hereby give permission for release of the above information to Simcoe Habilitation Services Inc. and its agents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\* If signature is not that of client then must**  **Date**

**be signed by legal guardian or POA**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please print name** *If signature is not that of client, specify relationship*