EPILEPSY ASSOCIATION OF CALGARY

Community Supports and Education for People with Epilepsy

epilepsycalgary.com

REFERRAL FORM

Please complete and return to Epilepsy Association of Calgary

Email: support@epilepsycalgary.com

Phone: 403-230-2764, Ext 105 || Fax: 403-230-5766

316, 4014 Macleod Trail SE | Calgary, AB | T2G 2R7

CLIENT CONTACT INFORMATION:

Referral Date: _____

Name: _____

Email: _____

Phone: _____

THIS REFERRAL IS FOR (Check all that apply):

☐ Adult ☐ Child/Youth 0-17 ☐ Parent

REASON FOR REFERRAL (check all that apply):

☐ New diagnosis

☐ Coping strategies

☐ Seizure education / First aid training

☐ Parent & family support

☐ School/Workplace support

☐ Volunteering / Social programs

Other: _____

IS THIS A SELF-REFERRAL? Yes_____ No_____

REFERRING PROFESSIONAL INFORMATION:

Referral made by (Name): _____

Phone: _____

Email: _____

☐ Client consents to follow-up by Epilepsy Association of Calgary