Referral Form

Please fill out and return to Epilepsy Association of Calgary
E: programs@epilepsycalgary.com P: 403-230-2764 F: 403-243-8283
#120, 6835 Railway Street SE Calgary, AB T2H 2V6

Date of Referral: ______________________________

Name: ______________________________

Preferred pronouns:

☐ She/Her

☐ He/Him

☐ They/Them

☐ N/A

☐ Other

Date of Birth: ______________________________

If under 18, please provide parent/guardian name and contact information:

____

Address: ______________________________

City: ______________________________ Postal Code: ______________________________

E-mail: ______________________________ Phone: ______________________________

What is the best way to contact you? ______________ Can we leave a voicemail? ______________

How are you impacted by epilepsy?

☐ I have been diagnosed with Epilepsy ☐ Family Member

☐ Medical/community professional ☐ Employer

☐ Caregiver ☐ Other ______________

Reason for Referral (check all that apply)

- ☐ New Diagnosis
- ☐ Seizure Education/First Aid
- ☐ Caregiver Support
- ☐ School or workplace support
- ☐ Volunteering/Social Programs
- ☐ Other

OR:

Which services would you like more information about?

- ☐ PACES (Group sessions for a person that would like to learn more about their Epilepsy)
- ☐ UPLIFT (Group sessions for a person living with Epilepsy that is wanting support to learn more/manage their anxiety/depression)
- ☐ HOBSCOTCH (1 on 1 memory and attention coaching)
- ☐ Short-Term Counselling
- ☐ Webinars
- ☐ Support Groups
- ☐ Peer 2 Peer
- ☐ Camp Fireworks
- ☐ Volunteering
- ☐ Other

Referral Made By: ______________________________

Phone: ____________________ Fax: ____________________

Consent to contact (Client/guardian signature): ______________________________