Halton Healthcare

Michael Lang, BSc MD FRCPC
Physical Medicine & Rehabilitation

Requisition for Comprehensive Spasticity Management Clinic

Patient Name: _____ **Birth date:** _____
(YYYY / MM / DD)

Health Card Number: _____ **Gender:** ___ **M** ___ **F**

Address: _____

Home Phone: (___) _____ **Work Phone:** (___) _____

Referring Physician: _____ **Billing Number:** _____

Referring Physician Phone Number: (___) _____ **Fax:** (___) _____

Referring Physician Address: _____

_____

Diagnosis (please check one):

Spasticity due to: ☐ Stroke ☐ Traumatic Brain Injury ☐ Spinal Cord Injury ☐ Multiple Sclerosis ☐ Cerebral Palsy
☐Other: _____

Medical History:

Current Medications:
Coumadin? ☐Yes ☐No

Anti-Spasticity Medications Previously Tried:

	Dosage:
☐ Baclofen	_____
☐ Tizanidine (Zanaflex)	_____
☐ Dantrolene	_____
☐ Benzodiazepam	_____
☐ Botox	_____
☐ Other_____	_____

For office use only:
Date received:_____ Appointment date/time: _____

327 Reynolds Street, Oakville ON L6J 3L7 Ph 905-845-2571 ext 3545 Fax 905-338-4453
www.haltonhealthcare.com