WEST PARK HEALTHCARE CENTRE
REHABILITATION, COMPLEX CONTINUING AND LONG-TERM CARE

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Requisition for Comprehensive Spasticity Management Clinic

Patient Name: _____ **Date of Birth:** _____
(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		Dosage
☐ Baclofen	_____	☐ Benzodiazepam	_____
☐ Tizanidine (Zanaflex)	_____	☐ Dantrolene	_____
☐ Botox	_____	☐ Other	_____

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