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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: ____

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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:** ___________________________