Halton Healthcare

Oakville Trafalgar Memorial Hospital
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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: _____

LIMBS TO BE ASSESSED - **Leg**: ❒ Right ❒ Left **Arm**: ❒ Right ❒ Left

MEDICAL HISTORY: _____

_____

_____

CURRENT MEDICATIONS – ❒ List attached

_____

_____

Coumadin: ❒ Yes ❒ No

Anti-Spasticity Medications Previously Tried:

❒ Baclofen Dose: _____

❒ Tizanidine (Zanaflex) Dose: _____

❒ Dantrolene Dose: _____

❒ Benzodiazepam Dose: _____

❒ Botox Dose: _____

❒ Other: _____ Dose: _____

For Office Use Only

Date Received: _____ Appointment Date/Time: _____