iScope Concussion and Pain Clinics
89 Queensway West, Suite 500, Mississauga, ON L5B 2V2
951 Wilson Ave Unit 17, Toronto, ON M3K 2A7
Phone: (416) 900-7007 Toll-free: 1-888-550-5508
Please send referrals by fax or email: (416) 900-7006 or intake@myiscope.com

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:

Anticoagulant? ❑ **Yes** ❑ **No**

If yes - specify which one:

Anti-Spasticity Medications previously tried:

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

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