Adult Intrathecal Baclofen (ITB) Program
NEW PATIENT REFERRAL

Date: _____

Attention: Intrathecal Baclofen (ITB) Program
Lyndhurst Centre, Toronto Rehabilitation Institute
520 Sutherland Drive, Toronto, ON M4G 3V9 CANADA
Telephone: (416) 597-3422 Extension 5764
Email: itb@uhn.ca | Fax: (416) 597-7042

Patient Name:	
Health Card Number:	**Date of Birth** (dd/mmm/yy)**:**
Ambulatory / Non-Ambulatory (Please circle)	**Male / Female** (Please circle)
Address:	
Phone Number:	
Caregiver Name (if applicable)**:**	
Service Requested (please check box on left)**:**	
	New consult for possible treatment with Intrathecal Baclofen (ITB) Therapy
	Existing ITB pump, transition from pediatric to adult program
	Existing ITB pump, adult patient implanted outside GTA, transition to follow-up at Lyndhurst Centre
Diagnosis:	
Reason for Consult:	
Please provide a detailed history of all current & prior spasticity treatments including the name of medication, dose, length of trial, and outcome, i.e. ineffective, unable to tolerate (please list side effects):	
For existing ITB patients, please attach details of surgery, pump history, and current pump information:	
Any treatment compliance concerns? (If yes, please describe)	
Attachments (Please enclose relevant history/investigations/reports):	
Referring Physician Information	
Name:	**Facility:**
OHIP Billing Number:	
Address:	
Phone:	**Fax:**
Referring Physician Signature:	