Royal Victoria Regional Health Centre

# Ambulatory Rehabilitation Day Program Referral

Phone: 705-739-5602
Fax: 705-739-5688

Patient Name: _____

DOB: _____

HRN: _____

**Rehab Population:** ☐ Amputee ☐ Confirmed Stroke

## Section 1: Demographic Information

Home Address:

Home Phone: Alternate Phone:

Health Card: Version: Expiry Date (if applicable):

Provide name and contact number to arrange appointments if different from client.
Substitute Decision Maker (SDM)/Power of Attorney (POA)/ Emergency Contact Information:
Name: Phone:
Relationship to Client:

Family Physician's contact Information: ☐ No Family Physician
Name: Phone:
Address: Fax:

## Section 2: Referral Information

**Referral Date:**

Referral Contact: Name/Position:
Phone: Organization & Program/Service:

Client is Currently:
- ☐ At Home
- ☐ Other (specify)

If Client is in Hospital: Date of Admission: _____ (yyyy/mm/dd)
Planned Date of Discharge: _____ (yyyy/mm/dd)

Rehab Services Requested:
- ☐ Occupational Therapy ☐ Physiotherapy
- ☐ Nursing ☐ Speech Language Pathology
- ☐ Social Work

FIM Scores Applicable: ☐ No ☐ Yes (please state all available scores)
- ☐ Alpha FIM
- ☐ Rehab Admission FIM
- ☐ Discharge FIM

Is Client Currently Receiving other Rehab Services ☐ No ☐ Yes (specify)

## Section 3: Reason for Referral

- ☐ Speech
- ☐ Cognition/Cognitive Communication
- ☐ Upper Extremity
- ☐ Lower Extremity
- ☐ Sensory
- ☐ Perception
- ☐ Balance
- ☐ Gait
- ☐ Finances
- ☐ Stroke Education
- ☐ Mood/Depression
- ☐ Other:

**For Administrative Use ONLY.**
**Date Referral Received:**
**Date of Initial Contact:**
**Notes:**

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## Section 4: Relevant Medical Information

Allergies: □ No □ Yes

Primary Diagnosis & History of Presenting Illness (relevant to reason for referral):

Date of Injury/Onset: _____(yyyy/mm/dd)

Past Medical/Surgical/Mental Health History (relevant to the rehab referral)

Infectious Disease: □ No □ Yes (specify) □ Unknown
MRSA: □ No □ Yes Location: _____
VRE: □ No □ Yes Location: _____
ESBL: □ No □ Yes
C-Difficile: □ No □ Yes
Other (specify):

Has the Ministry of Transportation Been Notified of Patient's Medical Status? □ No □ Yes

Transportation to the program has been arranged: □ No □ Yes

Reports Attached (e.g. CT scan, OT/PT, SLP/SW notes, etc.) □ Yes □ No

Please fax completed referral form including all relevant work-ups to the Day Rehab Program 705-739-5688

Signature of Referring Physician _____ Date _____

Referring Physician Name Print _____ Physician Billing Number _____

Physician Office Phone _____ Physician Office Fax _____

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**Notes:**