Ambulatory Rehabilitation Day Program (RDP) Referral

Royal Victoria Regional Health Centre

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

Patient Name: _____

DOB: _____

HRN: _____

Referral Date:

Rehab Population: ☐ Amputee ☐ Confirmed Stroke

Referral Criteria (please select)

☐ Referred by Physician or Primary Care Provider (PCP)
☐ Stroke Referrals: Confirmed diagnosis of **stroke that occurred within the past 3 months.**
☐ Amputee Referrals: Requires prosthetic gait training.
☐ Patient is **medically stable** and **activity tolerance can support active participation** in outpatient therapy.
☐ The patient is **not** a resident of a Long-Term Care facility.
☐ The patient **demonstrates rehabilitation potential.**
☐ The patient has functional **goals** attainable in **up to 12 – 14 weeks** of outpatient therapy.
☐ The patient **can transfer between level surfaces with moderate assistance of two people** (Note: patients requiring the use of a mechanical lift are not eligible to be admitted to the program).
☐ The patient is an active participant in program treatment and goal development.
☐ The patient has supports and products available to manage bladder and bowel incontinence (if applicable).

Section 1: Demographic Information

Home Address:

Home Phone: Alternate Phone:

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

Alternate/Emergency Contact Information:
Name: _____ Phone: _____
Relationship to Client: _____
☐ Alternate Contact to be used for booking appointments

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

Section 2: Referral Information

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 ☐ Speech Language Pathology
☐ Social Work ☐ Nursing/Education

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

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

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Is Client Currently Receiving Other Rehab Services (including HCC Stroke Pathway)
☐ No ☐ Yes (specify)

Section 3: Reason for Referral

☐ Amputee Prosthetic Gait Training

Outpatient Stroke Services:

☐ Swallowing	☐ Upper Extremity Neurorehabilitation	☐ Finances/Resource Counselling
☐ Communication	☐ Lower Extremity Neurorehabilitation	☐ Caregiver Support
☐ Cognition	☐ Gait Retraining	☐ Mood/Depression
☐ Visual/Perceptual	☐ Other:	

Section 4: Relevant Medical Information

Allergies: ☐ No ☐ Yes
If Yes, specify:

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 ☐ Unknown

Required Reports Attached:
☐ CT or MRI Report confirming Stroke
☐ Specialist Consult Notes (e.g. Neurologist, Physiatrist)
☐ Allied Health Notes
☐ Results from Standardized Assessments (e.g. MoCA)

Please **fax** completed referral form including all required reports to the Rehabilitation Day Program **705-739-5688**

Signature of Referring Physician/Primary Care Provider (PCP): _____

Name Referring Physician/PCP (please print): _____ Date _____

Physician Office Phone _____ Physician Office Fax _____

Incomplete/Illegible referrals will be returned, and referrals will not be processed until all relevant documentation has been received

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