Eastern Health

Rehabilitation & Continuing Care Program

Rehabilitation Day Services REFERRAL FORM (Part I)

Incomplete Referrals will be returned

Phone: 777-6531/ Fax: 777-7848

CL1960 1383 09 2015

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Allergies: ☐ No Known

Referral Source: _____

Gender: _____ Marital Status: _____

Current Address: _____

Permanent Address (if different from above): _____

Telephone: _____

Contact Person: _____ Contact Person Telephone: _____

Family Physician: _____

Does client consent to referral? ☐ Yes ☐ No

☐ Single Discipline Only (Only complete Part I) ☐ Team Referral (Complete Part I and II for Team Referral)

Reason for Referral: _____

What service(s) do you anticipate your client/patient will need? ** Driving Assessment referral requires a specific referral form

☐ Dietitian
☐ Occupational Therapy
☐ Psychology
☐ Therapeutic Recreation
☐ Medicine
☐ Physiotherapy
☐ Social Work
☐ Nursing
☐ Prosthetics/Orthotics
☐ Speech-Language Pathology

(Attach completed Diagnostic Imaging Requisition for Modified Barium Swallows)

Medical Information

Primary Diagnosis: _____ Date Diagnosed: DD/MONTH/YYYY

Other relevant medical history: _____

Contact Precautions: ☐ Yes ☐ No Type: ☐ MRSA ☐ VRE ☐ Other _____

Name: _____ Date: DD/MONTH/YYYY

Signature/Status: _____

Office Use Only

T2: (Received) DD/MONTH/YYYY T3: (Reviewed) DD/MONTH/YYYY

Priority: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Name: _____ Date: DD/MONTH/YYYY

Signature/Status: _____

Eastern Health

Rehabilitation & Continuing Care Program

Rehabilitation Day Services REFERRAL FORM (Part II)

Incomplete Referrals will be returned

Phone: 777-6531/ Fax: 777-7848

CL1960 1383 09 2015

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Transfers:

☐ Independent ☐ Supervision ☐ 1 person ☐ 2 person ☐ Transfer aide (specify) _____

Ambulation:

☐ Independent ☐ Supervision ☐ 1 person ☐ 2 person ☐ Mobility aide (specify) _____

Toileting:

☐ Independent ☐ Supervision ☐ 1 person ☐ 2 person ☐ Mobility aide (specify) _____

If patient requires assistance, do they have someone to assist them while attending therapy? ☐ Yes ☐ No

Communication: ☐ functional ☐ impaired

Comments: _____

Memory: Impairment? ☐ Yes ☐ No

Comments: _____

Behavior Issues (e.g. physical aggression, verbal aggression, wandering): ☐ Yes ☐ No

Comments: _____

Additional Information: _____

Name: _____ Date: DD/MONTH/YYYY

Signature/Status: _____