NL Health Services

REHABILITATION, GERIATRICS AND PALLIATIVE CARE

Rehabilitation Day Services Referral (Part I)

Telephone: 709-777-6531 Fax:709-777-7848

Incomplete referrals will be returned

CL1960 1383 09 2015

Name:

HCN:

Date of Birth:

Date: DD/MONTH/YYYY

Allergies: ☐ No Known

Current Address: _____

Permanent Address (if different from above): _____

Telephone: _____

Contact Person: _____ Contact Person Telephone: _____

Family Physician: _____

Referral Source: _____ Referral Source Telephone: _____

Does client consent to referral: ☐ Yes ☐ No

Does client have private insurance: ☐ Yes ☐ No

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
☐ Physiotherapy
☐ Social Work
☐ Nursing
☐ 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: _____

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REHABILITATION, GERIATRICS AND PALLIATIVE CARE

Rehabilitation Day Services Referral (Part II)

Telephone: 709-777-6531 Fax:709-777-7848

Incomplete referrals will be returned

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: