HÔTEL-DIEU GRACE HEALTHCARE
ESTD 1888

Specialized Neurologic and Complex Rehab Outpatient Clinic Referral Form

☐ **Rehab Outreach (Ext. 75116)**
☐ **Outpatients (Ext. 75200)**

Fax 519-257-5299

Specialized Neurologic and Complex Rehab Outpatient Clinic Referral Form

CLIENT INFORMATION	
Name:	DOB (MM/DD/YY):
Address:	City/Town: Postal Code:
Phone #:	Alternate Phone #:
Health Card Number:	Version Code:
Does the client have a Substitute Decision Maker: ☐ Yes ☐ No If YES, please provide: Name:	Phone #: Relationship to Client:
Does client consent to referral? ☐ Yes ☐ No	
Employment Status: ☐ Unemployed ☐ Retired ☐ Working	
Preferred Language: ☐ English ☐ French ☐ Other (please indicate):	

DRIVING INFORMATION
Has the Ministry of Transportation been informed the client has a medical condition that may affect their ability to drive? ☐ Yes ☐ No
Will transportation be an issue? ☐ Yes ☐ No ☐ Family ☐ Transportation Service

PHYSICIAN INFORMATION	
Family Physician:	Tel #:
Referring Physician: Signature: _____	Tel #:
Referral Source: ☐ Acute – WRH ☐ Erie Shores Healthcare ☐ Family Physician ☐ Specialist	
Name of person filling out this form:	Tel #:

REFERRAL CRITERIA
Referring Diagnosis: Date of Onset:
Disciplines Referred: ☐ PT ☐ OT ☐ SLP ☐ Clinical Dysphagia Assessment ☐ SW
Is this referral a result of a work related injury: ☐ Yes ☐ No
Is this referral a result of a motor vehicle accident: ☐ Yes ☐ No

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REASONS FOR REFERRAL	
☐ difficulty with arm and hand function	☐ difficulty returning to normal activities
☐ difficulty with walking and getting around	☐ taking care of self
☐ improve balance/decrease falls	☐ eating well and preparing meals
☐ difficulty with vision and perception	☐ fatigue
☐ talking	☐ difficulty with memory and/or thinking
☐ understanding	☐ concerned about finances
☐ difficulty swallowing	☐ impulsiveness
☐ managing emotional changes	☐ other
☐ adjusting to life after stroke	

PATIENT HISTORY
Relevant Medical History (includes history of seizures, dementia, etc):
Does the client (and/or family member) have a history of Responsive Behaviours: ☐ Yes ☐ No If YES, please describe:
Does the client have a history of Substance Use, Criminal Offences/Charges, Psychiatric Diagnoses ☐ Yes ☐ No If YES, please describe:
Infection Control: ☐ MRSA ☐ VRE ☐ CDIFF ☐ Cytotoxic Meds ☐ Other
Allergies (including Latex and Environmental Reaction): ☐ Yes ☐ No If YES, please specify allergy and reaction:
Is the client currently involved with the LHIN? ☐ Yes ☐ No If YES, please specify:
Is the client currently involved with other community agencies or services? ☐ Yes ☐ No If YES, please specify:

Please attach any relevant reports/discharge summaries and fax completed referral to: (519) 257-5299