

OUTPATIENT/AMBULATORY REHAB REFERRAL FORM*

The Outpatient/Ambulatory Rehab Referral Form is to be used for referrals to multiple rehab services provided by the GTA Rehab Network member organizations. This referral form is not intended to be used for referrals to medical/diagnostic services.

Note: The rehab programs/services offered by organizations may vary. For detailed information about programs offered by specific organizations, please refer to Rehab Finder at www.gtarehabnetwork.ca/RehabFinder.asp or contact the organization directly.

The development of this new form has been supported by funding from the Toronto Central LHIN.

Please note: Acute care referrers in Toronto who use the E-Stroke Rehab Referral system for stroke rehab referrals should continue to use the electronic referral system for outpatient referrals.

Referrers, when making an outpatient rehab referral, consider

- ✓ If the client is able to access transportation to/from the program
- ✓ The inclusion / exclusion criteria of the rehab service to which you are applying. For example, wandering might be an exclusion criterion unless the client is accompanied by a caregiver.
(Descriptions of rehab services / programs offered by GTA Rehab Network members can be found on **Rehab Finder** at www.gtarehabnetwork.ca/RehabFinder.asp)

Rehab referral receivers, when reviewing the Outpatient/Ambulatory Rehab Referral...

- ✓ If the client does not meet the eligibility criteria of your program, provide information on rehab services / program options offered by other programs/organizations or community services

For each referral...

- ✓ Complete each section of the referral form
- ✓ Fax the referral directly to the program/service you are requesting as per the organization's intake process (Information on the application process is available on **Rehab Finder** at www.gtarehabnetwork.ca/RehabFinder.asp)

*Copies of the Outpatient / Ambulatory Rehab Referral Form can be downloaded from the GTA Rehab Network's website at www.gtarehabnetwork.ca/referral_forms.asp.

OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

SECTION 1: DEMOGRAPHIC INFORMATION		PATIENT'S NAME: _____ <small>(LAST NAME, FIRST NAME)</small>	
GENDER <input type="checkbox"/> M <input type="checkbox"/> F		DOB _____ (yyyy/mm/dd)	
HOME ADDRESS _____		Apt # _____	Postal Code _____
Home Telephone Number : _____		Alternate Phone Number: _____	
HEALTH CARD NUMBER _____		Version _____	Expiry Date (If available) _____
Province/Territory issuing Health Card: <input type="checkbox"/> Ontario Country/Province # _____		<input type="checkbox"/> Other (Specify): _____	
RESPONSIBILITY FOR PAYMENT (IF NOT OHIP)			
<input type="checkbox"/> Private Insurer <input type="checkbox"/> WSIB _____ <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Veteran <input type="checkbox"/> Self Pay <input type="checkbox"/> IFH (Interim Federal Health Grant) _____ <input type="checkbox"/> Out of Province _____			
SPEAKS, UNDERSTANDS ENGLISH <input type="checkbox"/> Yes <input type="checkbox"/> Minimal <input type="checkbox"/> No			
If Minimal/No, is family interpreter available? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, interpreter is needed for what language? _____			
SUBSTITUTE DECISION MAKER (SDM) / POWER OF ATTORNEY (POA) / EMERGENCY CONTACT INFORMATION			
Name: _____		Daytime Tel. No. _____	Relationship to Client: _____
PRIMARY CONTACT TO ARRANGE APPOINTMENTS: <input type="checkbox"/> Client <input type="checkbox"/> SDM/POA <input type="checkbox"/> Emergency Contact			
Provide name and daytime telephone if different from client or individual listed above _____			
FAMILY PHYSICIAN'S CONTACT INFORMATION: <input type="checkbox"/> No Family Physician			
Name: _____		Phone: _____	Fax: _____
Address: _____		Billing No. (if available): _____	
SECTION 2: REFERRAL INFORMATION		REFERRAL DATE: _____ (YYYY/MM/DD)	
REFERRAL CONTACT: Contact name/position: _____ Phone: () _____			
Organization & Program/Service: _____ Pager: () _____			
CLIENT IS CURRENTLY: <input type="checkbox"/> at home <input type="checkbox"/> other (specify) _____			
IF CLIENT IS IN HOSPITAL: Date of Admission: ____ / ____ / ____ (YYYY/MM/DD) Planned Date of Discharge: ____ / ____ / ____ YYYY/MM/DD			
PRIMARY DIAGNOSIS: _____			
REHAB POPULATION: <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> General/Medical <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neuro <input type="checkbox"/> Oncology <input type="checkbox"/> Pulmonary <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Trauma <input type="checkbox"/> Transplant <input type="checkbox"/> Other _____			
REHAB SERVICE(S) REQUESTED: <i>Note: Not all organizations provide all services listed below.</i> For detailed information about programs offered by specific organizations, please refer to Rehab Finder at www.gtarehabnetwork.ca/RehabFinder.asp or contact the organization directly.			
<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Dietician <input type="checkbox"/> Social Work <input type="checkbox"/> Nursing <input type="checkbox"/> Physiatry <input type="checkbox"/> Psychology <input type="checkbox"/> Therapeutic Recreation <input type="checkbox"/> Speech Language Pathology / Swallowing <input type="checkbox"/> Speech Language Pathology/ Communication <input type="checkbox"/> Psychiatry <input type="checkbox"/> Other rehab services required (e.g. Seating Clinic, Vocational Rehab, Pain Management Clinic, Augmentative Communication/Writing Clinic etc.) Specify: _____			
SPECIAL CONSIDERATIONS: (E.G. HOUSING, TRANSPORTATION, SOCIAL SUPPORT, VISUAL IMPAIRMENT, OTHER IDENTIFIED RISKS)			
(If available, attach Social Work report)			
IS CLIENT CURRENTLY RECEIVING OTHER REHAB SERVICES? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____			
REPORTS ATTACHED? (e.g. CT scan, OT/PT/SLP/SW notes etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			

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SECTION 3: REASON FOR REFERRAL
PATIENT'S NAME: _____
(LAST NAME, FIRST NAME)

 To be completed by Physician *or* Physician Designate *or* allied health professional (e.g. PT, OT, SLP, SW, RN)

PATIENT GOALS/TREATMENT PLAN (*Identify SMART goals – specific, measurable, attainable, realistic and timely*)

BASIC PERSONAL ISSUES IDENTIFIED? No Yes (specify below)

 Self-care Toileting Pain Medication Management Other: _____

Goals/Comments:
MOBILITY ISSUES IDENTIFIED? No Yes (specify below)

 Ambulation: Independent Assistance Supervision Mobility Aid: _____

 Transfers: Independent Assistance Supervision If aid required: _____

Activity Tolerance (specify): _____

 Paresis/paralysis Falls/history of falls Other: _____

Goals/Comments:
BEHAVIOUR ISSUES IDENTIFIED? No Yes (specify below)

 Wandering Aggressiveness Other: _____

Goals/Comments:
SWALLOWING ISSUES IDENTIFIED? No Yes (specify below)

 Intact, regular diet Dental soft diet Minced diet Pureed diet Thickened fluids

Goals/Comments:
COMMUNICATION ISSUES IDENTIFIED? No Yes (specify below)

 Hearing Vision Language, comprehension Language, expression Speech Dysarthria Speech Apraxia

 Other (specify)

Goals/Comments:
COGNITIVE ISSUES IDENTIFIED? No Yes (specify below)

 Orientation Participation Judgment Carryover/New Learning Memory Frustration tolerance Other: _____

Goals/Comments:
COMPLETED BY:
PHONE:
DATE:

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SECTION 4: RELEVANT MEDICAL INFORMATION

PATIENT'S NAME: _____
(LAST NAME, FIRST NAME)

To be completed by Physician or Physician Designate

ALLERGIES: No Yes (list):

PRIMARY DIAGNOSIS & HISTORY OF PRESENTING ILLNESS (relevant to reason for referral): Date of Injury/Onset: _____ yyyy/mm/dd

PAST MEDICAL / SURGICAL HISTORY (relevant to rehab referral): Date of Surgery : _____ yyyy/mm/dd

For ABI/Neuro Referrals Only (where applicable):

Trauma No Yes Seizures: No Yes Loss of Consciousness: No Yes
 Post-Traumatic Amnesia Resolved? No Yes Previous history of ABI? No Yes _____
 CT/MRI Date of Completion: ____ / ____ / ____ Facility: _____ (attach report)

RELEVANT MENTAL HEALTH HISTORY: No Yes If yes, describe history, current status including suicide risk, provide recent consult notes and details of follow-up arrangements:

Followed by ACT Team/Case Manager? No Yes (Specify contact information):

SUBSTANCE ABUSE: History of Substance Abuse: No Yes History not available
 Current Substance Abuse: No Yes Not known Substance Abuse Treatment Recommended: No Yes

INFECTIOUS DISEASE: No Yes (specify below) Unknown
 Does individual currently have:
 MRSA: No Yes Location: _____ VRE: No Yes Location: _____
 C-Difficile: No Yes Other(specify): _____

WEIGHT BEARING STATUS AS ORDERED BY MD: No restrictions
 Left: Right: As tolerated Partial _____% Touch weight bearing Non weight bearing
 Precautions and restrictions: _____ Date to become weight bearing: _____

CARDIOVASCULAR & PULMONARY HISTORY: (As applicable) <input type="checkbox"/> None known		Known Cardiac Risk Factors: <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes I / II <input type="checkbox"/> Family History <input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Smoking
Pacemaker/ICD <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, name of pacer clinic: _____		
Previous CVA <input type="checkbox"/> No <input type="checkbox"/> Yes	Pulmonary Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	
Peripheral Vascular Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Myocardial Infarction <input type="checkbox"/> No <input type="checkbox"/> Yes	
Heart Failure <input type="checkbox"/> No <input type="checkbox"/> Yes	Atrial Fibrillation/Other arrhythmias <input type="checkbox"/> No <input type="checkbox"/> Yes	

SAFE TO PARTICIPATE IN WARM THERAPEUTIC POOL (HYDROTHERAPY) IF THERAPIST INDICATES THIS IS NECESSARY? No Yes

HAS THE MINISTRY OF TRANSPORTATION BEEN NOTIFIED OF PATIENT'S MEDICAL STATUS? No Yes

REFERRING PHYSICIAN: I authorize a referral for this individual for the services specified.

Name: _____ Phone: () _____

Signature: _____ Date: _____ (yyyy/mm/dd)

Billing No. (if available): _____ Hospital: _____

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SECTION 5: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager)

I agree that _____ may release my personal health information to make a referral.
(Referral source disclosing information)

Organization(s) referred to:

<input type="checkbox"/> Baycrest	<input type="checkbox"/> North York General Hospital	<input type="checkbox"/> The Scarborough Hospital	Other (specify): _____
<input type="checkbox"/> Bridgepoint Health	<input type="checkbox"/> Rouge Valley Health System	<input type="checkbox"/> Toronto Rehab	_____
<input type="checkbox"/> Credit Valley Hospital	<input type="checkbox"/> Southlake Regional Health Centre	<input type="checkbox"/> Trillium Health Centre	
<input type="checkbox"/> Halton Healthcare Services	<input type="checkbox"/> St. John's Rehab Hospital	<input type="checkbox"/> University Health Network	
<input type="checkbox"/> Lakeridge Health	<input type="checkbox"/> St. Joseph's Health Centre	<input type="checkbox"/> West Park Healthcare Centre	
<input type="checkbox"/> Markham Stouffville Hospital	<input type="checkbox"/> Sunnybrook Health Sciences Centre	<input type="checkbox"/> York Central Hospital	

To be completed for all referrals:

Print Name of Patient: _____

Signature of Patient/Substitute: _____

If unable to obtain signature, has verbal consent been obtained? Yes

Witness: _____
(Print name)

(Signature)

Name of Substitute: (Print name) _____

Relationship to patient, if signed by Substitute: _____

- Yes, an interpreter was used when consent was obtained.
 No interpreter was required.

Date:(YYYY/MM/DD) _____