NEURO REHAB PHYSIATRY CLINIC
Physical Medicine and Rehabilitation
Outpatient Referral Form

GRAND RIVER HOSPITAL
Advancing Exceptional Care

Freeport Campus, Pioneer Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-749-4300, ext. 7860 Fax: 519-894-8310

PHYSIATRY REFERRAL REQUIREMENTS:

For the referral to be considered, the following referral criteria must be met:

- ✓ There is a confirmed neurological diagnosis (for example, stroke, spinal cord injury, brain injury, neuromuscular condition).
- ✓ The condition is acute, or chronic with a deteriorated function requiring optimization.
- ✓ Relevant information must be included to allow for appropriate assessment:
- ✓ Summary of diagnostics
- ✓ Summary of past and present rehabilitation, if known
- ✓ Medical information including current medications

Additionally the client must meet all of the following criteria for the programs:

- ✓ Medically stable.
- ✓ Able to tolerate travel to and from the clinic. In some cases, virtual follow-up appointments may be offered.
- ✓ Physician referral is required for Physiatrist review.

Patient Identification

Last Name:	First Name:	Middle Initial:	Birth Date: (year/month/day)
Address:	City:	Province:	Postal Code:
Birth Sex: ❒Male ❒Female ❒Other_____		Gender: ❒Male ❒Female ❒Other_____	
Home Phone #:	Cell Phone #:	Health card #: Expiry:	Version Code:

Alternate Contact ❒Emergency Contact ❒Substitute Decision Maker (SDM) ❒Power of

Last Name:	First Name:	Relationship:
Home Phone #:	Business Phone #:	Cell Phone

To arrange appointments contact: ❒Patient ❒Alternate Contact ❒Other:_____

❒The patient/SDM has consented to messages being left at the above phone numbers.

Referral Request

REFERRING DIAGNOSIS:	
DATE OF ONSET:	
RELEVANT PAST MEDICAL HISTORY:	
GOALS / REQUESTS of referral (Current Status, Expected outcomes, etc.):	

***Please Note:** Relevant information that cannot be accessed on Cerner must be attached as above*

Does this person have *any current* ARO infection / isolation concerns? ❒Yes ❒No
(Please Specify): ❒MRSA ❒VRE ❒C.Diff ❒ESBL ❒Other: _____

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CURRENT THERAPY

Medication Profile (Please list or attach the current medication list with dosages)

Allergies (describe allergic reaction)

❒ None known ❒ Drug allergies_____ ❒Food or Environmental allergies_____

Allergic reaction:

Current Diet (including texture modifications):

Transportation (How will the patient get to the Grand River Hospital-Freeport Site Rehabilitation?)

☐Family/Friend will drive ☐Mobility Plus/Kiwanis Transit ☐Bus or Taxi ☐Patient will drive self

Special Considerations / Comments (e.g. language barriers, requires special assistance)

☐ ☐ The referral form was completed with the client/substitute decision maker, and the reason for the referral has been discussed.

Referral Source

Last Name:	First Name:	Office phone #:
Discipline:	Name of service:	Date: (year/month/day)

Family Physician

Last Name:	First Name:	Phone #:
		Fax #:

Referring Physician

Last Name:	First Name:	Phone #:
		Fax #:

Physician Signature (REQUIRED)

	Billing #:	Date: (year/month/day)

Fax Completed Form (2 pages) to Fax #: 519 894 8310
Please direct any questions via phone to #: **519 749 4300 ext. 7860**

NOTE: Please attach medication profile and all relevant reports.
All incomplete referral forms will be returned to referral source for completion

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