NEURO REHABILITATION CLINIC
Outpatient Referral Form

WRHN @ Midtown, Union Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-894-8340 Fax: 519-894-8307

NEUROREHABILITATION CLINIC REFERRAL REQUIREMENTS:

For the referral to be considered, one of the following referral criteria must be met. Has the individual experienced:

- ❑ Acute neurological (CNS) diagnosis, or
- ❑ Acute change in status of the neurological diagnosis, or
- ❑ Neurological diagnosis impacting recovery from an acute medical change.

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

- ✓ Must have specific attainable goals that can be met within the outpatient clinic.
- ✓ Demonstrates sufficient cognitive skills to participate in goal setting and to be able to integrate new learning into daily life.
- ✓ Minimum of **18** years of age.
- ✓ Medically stable.
- ✓ Able to tolerate travel to and from the clinic in addition to therapy
- ✓ Physician referral is required for assessment and treatment.

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 Attorney

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.

Services Requested

❑ Occupational Therapy ❑ Physiotherapy ❑ Recreation Therapy ❑ Social Work ❑ Speech Language Pathology ❑ Dietitian

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

*** EXPECTED DISCHARGE DATE (if still in hospital):**

***Please Note:** Recent discharge summaries and any relevant medical reports must be attached*

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

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GRAND RIVER HOSPITAL

Driving Information *Please discuss any medical/functional concerns with the patient before submitting this referral*

Is the patient medically fit to drive? ❒Yes ❒No ❒Uncertain

Has the Ministry of Transportation been informed that the patient has a medical condition that may affect their ability to drive?

❒Yes ❒No ❒Uncertain

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 WRHN @ Chicopee, Neuro Rehabilitation Clinic?)

❒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 etc.)

☐ ☐ 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 #: 519-894-8307
Please direct any questions via phone to #: **519-894-8340**

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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