GRAND RIVER HOSPITAL

Neuro Rehabilitation Clinic Referral Form

Grand River Hospital, Freeport Site: 3570 King St East Kitchener, ON N2A 2W1

Phone: 519 894 8340 Fax: 519 894 8307

NEURO REHABILITATION CLINIC REFERRAL REQUIREMENTS:

In order for 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.
- ✓ Medically stable.
- ✓ Able to tolerate travel to and from the clinic in addition to therapy.
- ✓ Demonstrates sufficient cognitive skills to participate in goal setting and to be able to integrate new learning into daily life.
- ✓ Minimum of 16 years of age.
- ✓ Physician referral required for assessment and treatment.

Patient Identification

Last name	First name	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 ❒Power of Attorney

Last name	First name	Relationship
Home Phone	Business Phone	Cell Phone

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

❒Patient/Substitute Decision Maker 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 a *current* ARO infection / isolation concerns? ❒Yes ❒No
(Please Specify): ❒MRSA ❒VRE ❒C.Diff ❒ESBL ❒Other: ______________________________

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Driving Information ***Please discuss any medical/functional concerns with the patient prior to submitting this referral***
Is the patient medically fit to drive? ❐Yes ❐No ❐Uncertain
Has the Ministry of Transportation been informed that patient has a medical condition that may affect their ability to drive? ❐Yes ❐No ❐Uncertain

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

Allergies (describe allergic reaction)
❐ None known ❐ Drug allergies ____________________ ❐Food or Environmental allergies ____________________

Current Diet (including texture modifications):	

Transportation (How will patient get to the Grand River Hospital-Freeport Site Rehabilitation Clinic?)			
❐Family/Friend will drive	❐Mobility Plus/Kiwanis Transit	❐Bus or Taxi	❐ Patient will drive self

Special Considerations / Comments
❐ Referral form was completed with client/substitute decision maker, and reason for referral has been discussed.

Referral Source		
Last name	First name	Office phone number
Discipline	Name of service	Date year / month / day

Family Physician		
Last name	First name	Phone Number:
		Fax Number:

Referring Physician		
Last name	First name	Phone Number:
		Fax Number:
Physician Signature (REQUIRED)		
		Date year / month / day

Fax Completed Form (2 pages) to - Fax: 519-894-8307
Please direct any questions to - Phone: 519-894-8340

NOTE: Please attach medication profile and all relevant reports.

All incomplete referral forms will be returned to referral source for completion