



WRHN
Waterloo Regional
Health Network

NEURO REHAB PHYSIATRY CLINIC

Physical Medicine and Rehabilitation Outpatient Referral Form

WRHN @ Chicopee, 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> 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: _____

**WRHN**Waterloo Regional
Health Network**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 WRHN @ Chicopee 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)
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Fax Completed Form (2 pages) to Fax #: 519 894 8310Please 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