Office Use Only: Date Received

COMPREHENSIVE SPASTICITY MANAGEMENT PROGRAM REFERRAL FORM
Regional Rehabilitation Centre

PATIENT DEMOGRAPHICS AND HISTORY

Patient's Name ____________________

Date of Birth ____________________

Health Card Number ____________ Ver ______

Present Address ____________________

PERSON TO CONTACT TO MAKE FIRST APPOINTMENT

Name ____________________ Phone ____________ Relationship ____________

ARE THERE ANY TIMES THE PATIENT WILL NOT BE AVAILABLE FOR TREATMENT? ____________________

DIAGNOSIS RELEVANT TO THIS REFERRAL ____________________

Please describe any previous treatment for spasticity ____________________

Precautions ____________________

If Inpatient: Current Location ____________ Expected D/C Date ____________

TRANSPORTATION: What method of transportation has been planned? ____________________

❑ DARTS — DARTS #: ____________ ❑ PRIVATE: ____________ ❑ OTHER: ____________

LANGUAGE: Spoken/Understood: English Other ____________ Interpreter available if needed? ❑ Yes ❑ No

Name and Contact Information of Interpreter if needed ____________________

CURRENT MOBILITY: Inside ________ Aid ________ Outside ________ Aid ________

DESCRIBE SPECIFIC ISSUES AND TREATMENT GOALS (check all that apply)

❑ Transfers ❑ Hygiene ❑ Positioning ❑ Prevention of Skin Breakdown
❑ AFO Fit ❑ Bracing Fit ❑ Spasms ❑ Clonus ❑ Mobility

Notes: ____________________

REFERRAL SOURCE: Name ____________________ Discipline ____________

LOCATION: ____________________ Phone # ____________

REFERRING PHYSICIAN ____________________ **SIGNATURE** ____________

PHONE ____________________ **FAX** ____________

REFERRING PHYSICIAN BILLING NUMBER ____________________

PLEASE FAX COMPLETED REFERRAL FORM ALONG WITH CURRENT MEDICATION LIST AND ANY ADDITIONAL DOCUMENTATION TO 905-577-8231