Hamilton Health Sciences

**REGIONAL REHABILITATION OUTPATIENT SERVICES REFERRAL FORM**

| Client Information | |
|---|---|
| Name: | DOB (Y/M/D): |
| Address: | Postal Code: |
| Phone Number: | Gender: |
| WSIB# (if applicable): | |
| Health Card #: | Version: |
| Has the client consented to this referral? Yes ☐ No ☐ | |
| **Family Physician Information** | |
| Family Physician Name: | |
| Tel.#: | Fax#: |
| **Client Diagnosis Confirmed With Imaging** | |
| Diagnosis: | |
| Date of Onset: | Date of D/C if inpatient: |

**Functional Needs To Restore**

Current Difficulties With:

| | | |
|---|---|---|
| ☐ Arm/Hand Function | ☐ Taking Medication(s) | ☐ Perception (e.g. lack of body awareness in space/inattention) |
| ☐ Leg/Foot Function | ☐ Taking care of self (e.g. bathing, dressing etc.) | ☐ Return to Driving |
| ☐ Swallowing | ☐ Walking | ☐ Preparing Meals |
| ☐ Speaking | ☐ Transfers (e.g. bed to chair, tub/toilet) | ☐ Paying Bills |
| ☐ Understanding | ☐ Balance/Falls | ☐ Coping with life after Injury |
| ☐ Reading &/or Writing | ☐ Stair Climbing | ☐ Financial strains/needs |
| ☐ Vision | ☐ Wheelchair skills | |
| ☐ Memory &/or Thinking | | |
| ☐ Other: | | |

**Transportation**

Has the Ministry of Transportation been informed that the client has a medical condition that may impact their ability to drive? ☐ Yes ☐ No ☐ Uncertain

What type of transportation is planned?

DARTS# (if applicable):

## Caregiver Information

Is a caregiver required for any of the following?

☐ Communication/Checking In ☐ Wayfinding ☐ Toileting

Has a caregiver been arranged for the above requirements? ☐ Yes ☐ No ☐ Unsure

## Person to Contact to Make First Appointment

| Name: | Phone#: | Relationship to Client: |
|---|---|---|
| | | |

## Has the Client been referred to any additional services? (Check all that apply).

| | |
|---|---|
| ☐ LHIN (homecare) | ☐ ABI Outreach |
| ☐ Neuropsychology | ☐ Spasticity Management Clinic |
| ☐ Prosthetics and Orthotics | ☐ Community Exercise Programs (i.e. YMCA, Stay Well) |
| ☐ Stroke Prevention Clinic | ☐ Goldies to Home |
| ☐ Cardiac Rehabilitation | ☐ SAM Aphasia Program |
| ☐ Neuro-ophthalmology | ☐ SCI Ontario |
| ☐ Stroke Support Group | ☐ Other: |
| ☐ Adult Wheelchair & Seating Clinic | |

## Referring Provider Information

Referring Provider:

| Tel.#: | Fax#: |
|---|---|

Physician/Nurse Practitioner Signature (REQUIRED):

**PLEASE FAX COMPLETED REFERRAL FORM TO: #905-521-2359**

Revised Jan 2020