

## Outpatient/Ambulatory Rehab Referral Form\*

The Outpatient/Ambulatory Rehab Referral Form is to be used for referrals to multiple rehab services provided by the GTA Rehab Network member organizations. This referral form is not intended to be used for referrals to medical/diagnostic services.

**Note: The rehab programs/services offered by organizations may vary.** For detailed information about programs offered by specific organizations, please refer to Rehab Finder at <http://www.gtarehabnetwork.ca/find-rehab-programs> or contact the organization directly.

The development of this new form has been supported by funding from the Toronto Central LHIN.

Please note: Acute care referrers in Toronto who use the E-Stroke Rehab Referral system for stroke rehab referrals should continue to use the electronic referral system for outpatient referrals.

### Referrers, when making an outpatient rehab referral, consider ....

- ✓ If the client is able to access transportation to/from the program
- ✓ The inclusion / exclusion criteria of the rehab service to which you are applying. For example, wandering might be an exclusion criterion unless the client is accompanied by a caregiver.  
(Descriptions of rehab services / programs offered by GTA Rehab Network members can be found on **Rehab Finder** at <http://www.gtarehabnetwork.ca/find-rehab-programs>)

### Rehab referral receivers, when reviewing the Outpatient/Ambulatory Rehab Referral...

- ✓ If the client does not meet the eligibility criteria of your program, provide information on rehab services / program options offered by other programs/organizations or community services

### For each referral...

- ✓ Complete each section of the referral form
- ✓ Fax the referral directly to the program/service you are requesting as per the organization's intake process (Information on the application process is available on **Rehab Finder** at <http://www.gtarehabnetwork.ca/find-rehab-programs>)

\*Copies of the Outpatient / Ambulatory Rehab Referral Form can be downloaded from the GTA Rehab Network's website at <http://www.gtarehabnetwork.ca/outpatient-ambulatory>.

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**OUTPATIENT/AMBULATORY REHAB REFERRAL FORM**

<b>SECTION 1: DEMOGRAPHIC INFORMATION</b>		<b>PATIENT'S NAME:</b> _____ <small>(LAST NAME, FIRST NAME)</small>	
<b>GENDER</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>DOB</b> _____ (yyyy/mm/dd)	
<b>HOME ADDRESS</b>		Apt # _____	Postal Code _____
Home Telephone Number : _____		Alternate Phone Number: _____	
<b>HEALTH CARD NUMBER</b>		<b>Version</b>	<b>Expiry Date (If available)</b>
Province/Territory issuing Health Card: <input type="checkbox"/> Ontario    Country/Province # _____		<input type="checkbox"/> Other (Specify): _____	
<b>RESPONSIBILITY FOR PAYMENT (IF NOT OHIP)</b>			
<input type="checkbox"/> Private Insurer <input type="checkbox"/> WSIB _____ <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Veteran <input type="checkbox"/> Self Pay <input type="checkbox"/> IFH (Interim Federal Health Grant) _____ <input type="checkbox"/> Out of Province _____			
<b>SPEAKS, UNDERSTANDS ENGLISH</b> <input type="checkbox"/> Yes <input type="checkbox"/> Minimal <input type="checkbox"/> No			
If Minimal/No, is family interpreter available? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, interpreter is needed for what language? _____			
<b>SUBSTITUTE DECISION MAKER (SDM) / POWER OF ATTORNEY (POA) / EMERGENCY CONTACT INFORMATION</b>			
Name: _____		Daytime Tel. No. _____	Relationship to Client: _____
<b>PRIMARY CONTACT TO ARRANGE APPOINTMENTS :</b> <input type="checkbox"/> Client <input type="checkbox"/> SDM/POA <input type="checkbox"/> Emergency Contact			
Provide name and daytime telephone if different from client or individual listed above _____			
<b>FAMILY PHYSICIAN'S CONTACT INFORMATION :</b> <input type="checkbox"/> No Family Physician			
Name: _____		Phone: _____	Fax: _____
Address: _____		Billing No. (if available): _____	
<b>SECTION 2: REFERRAL INFORMATION</b>		<b>REFERRAL DATE:</b> _____ (YYYY/MM/DD)	
<b>REFERRAL CONTACT:</b> Contact name/position: _____ Phone: (    ) _____			
Organization & Program/Service: _____ Pager: (    ) _____			
<b>CLIENT IS CURRENTLY:</b> <input type="checkbox"/> at home <input type="checkbox"/> other (specify) _____			
<b>IF CLIENT IS IN HOSPITAL:</b> Date of Admission: ____ / ____ / ____ (YYYY/MM/DD)    Planned Date of Discharge: ____ / ____ / ____ YYYY/MM/DD			
<b>PRIMARY DIAGNOSIS:</b>			
<b>REHAB POPULATION:</b> <input type="checkbox"/> ABI <input type="checkbox"/> Amputee <input type="checkbox"/> Burns <input type="checkbox"/> Cardiac <input type="checkbox"/> General/Medical <input type="checkbox"/> Geriatric <input type="checkbox"/> MSK <input type="checkbox"/> Neuro			
<input type="checkbox"/> Oncology <input type="checkbox"/> Pulmonary <input type="checkbox"/> Spinal Cord <input type="checkbox"/> Trauma <input type="checkbox"/> Transplant <input type="checkbox"/> Other _____			
<b>REHAB SERVICE(S) REQUESTED:</b> <i>Note: Not all organizations provide all services listed below.</i> For detailed information about programs offered by specific organizations, please refer to Rehab Finder at <a href="http://www.gtarehabnetwork.ca/find-rehab-programs">http://www.gtarehabnetwork.ca/find-rehab-programs</a> or contact the organization directly.			
<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Dietician <input type="checkbox"/> Social Work <input type="checkbox"/> Nursing <input type="checkbox"/> Psychiatry <input type="checkbox"/> Psychology <input type="checkbox"/> Therapeutic Recreation <input type="checkbox"/> Speech Language Pathology / Swallowing <input type="checkbox"/> Speech Language Pathology/ Communication <input type="checkbox"/> Psychiatry <input type="checkbox"/> Other rehab services required (e.g. Seating Clinic, Vocational Rehab, Pain Management Clinic, Augmentative Communication/Writing Clinic etc.) Specify: _____			
<b>SPECIAL CONSIDERATIONS: (E.G. HOUSING, TRANSPORTATION, SOCIAL SUPPORT, VISUAL IMPAIRMENT, OTHER IDENTIFIED RISKS)</b>			
(If available, attach Social Work report)			
<b>IS CLIENT CURRENTLY RECEIVING OTHER REHAB SERVICES?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes (specify) _____			
<b>REPORTS ATTACHED?</b> (e.g. CT scan, OT/PT/SLP/SW notes etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No			

**OUTPATIENT/AMBULATORY REHAB REFERRAL FORM**

**SECTION 3: REASON FOR REFERRAL**

**PATIENT'S NAME:** \_\_\_\_\_  
(LAST NAME, FIRST NAME)

To be completed by Physician or Physician Designate or allied health professional (e.g. PT, OT, SLP, SW, RN)

**PATIENT GOALS/TREATMENT PLAN** (Identify SMART goals – specific, measurable, attainable, realistic and timely)

**BASIC PERSONAL ISSUES IDENTIFIED?**  No  Yes (specify below)

Self-care     Toileting     Pain     Medication Management     Other: \_\_\_\_\_

Goals/Comments:

**MOBILITY ISSUES IDENTIFIED?**  No  Yes (specify below)

Ambulation:  Independent     Assistance     Supervision    Mobility Aid: \_\_\_\_\_

Transfers:  Independent     Assistance     Supervision    If aid required: \_\_\_\_\_

Activity Tolerance (specify): \_\_\_\_\_

Paresis/paralysis     Falls/history of falls     Other: \_\_\_\_\_

Goals/Comments:

**BEHAVIOUR ISSUES IDENTIFIED?**  No  Yes (specify below)

Wandering     Aggressiveness     Other: \_\_\_\_\_

Goals/Comments:

**SWALLOWING ISSUES IDENTIFIED?**  No  Yes (specify below)

Intact, regular diet     Dental soft diet     Minced diet     Pureed diet     Thickened fluids

Goals/Comments:

**COMMUNICATION ISSUES IDENTIFIED?**  No  Yes (specify below)

Hearing     Vision     Language, comprehension     Language, expression     Speech Dysarthria     Speech Apraxia

Other (specify)

Goals/Comments:

**COGNITIVE ISSUES IDENTIFIED?**  No  Yes (specify below)

Orientation     Participation     Judgment     Carryover/New Learning     Memory     Frustration tolerance     Other \_\_\_\_\_

Goals/Comments:

**COMPLETED BY:**

**PHONE:**

**DATE:**

**OUTPATIENT/AMBULATORY REHAB REFERRAL FORM**

**SECTION 4: RELEVANT MEDICAL INFORMATION**

**PATIENT'S NAME:** \_\_\_\_\_  
(LAST NAME, FIRST NAME)

To be completed by Physician or Physician Designate

**ALLERGIES:**  No  Yes (list):

**PRIMARY DIAGNOSIS & HISTORY OF PRESENTING ILLNESS (relevant to reason for referral):** **Date of Injury/Onset:** \_\_\_\_\_ yyyy/mm/dd

**PAST MEDICAL / SURGICAL HISTORY (relevant to rehab referral):** **Date of Surgery :** \_\_\_\_\_ yyyy/mm/dd

**For ABI/Neuro Referrals Only (where applicable):**

Trauma  No  Yes    Seizures:  No  Yes    Loss of Consciousness:  No  Yes  
 Post-Traumatic Amnesia Resolved?  No  Yes    Previous history of ABI?  No  Yes \_\_\_\_\_  
 CT/MRI Date of Completion: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Facility: \_\_\_\_\_ (attach report)

**RELEVANT MENTAL HEALTH HISTORY:**  No  Yes If yes, describe history, current status including suicide risk, provide recent consult notes and details of follow-up arrangements:

Followed by ACT Team/Case Manager?  No  Yes (Specify contact information):

**SUBSTANCE ABUSE:** History of Substance Abuse:  No  Yes  History not available  
 Current Substance Abuse:  No  Yes  Not known    Substance Abuse Treatment Recommended:  No  Yes

**INFECTIOUS DISEASE:**  No  Yes (specify below)  Unknown  
 Does individual currently have:  
 MRSA:  No  Yes Location: \_\_\_\_\_    VRE:  No  Yes Location: \_\_\_\_\_  
 C-Difficile:  No  Yes    Other(specify): \_\_\_\_\_

**WEIGHT BEARING STATUS AS ORDERED BY MD:**  No restrictions  
 Left:  Right:   As tolerated  Partial \_\_\_\_\_%     Touch weight bearing  Non weight bearing  
 Precautions and restrictions: \_\_\_\_\_    Date to become weight bearing: \_\_\_\_\_

<b>CARDIOVASCULAR &amp; PULMONARY HISTORY: (As applicable)</b> <input type="checkbox"/> None known		<b>Known Cardiac Risk Factors:</b>
Pacemaker/ICD <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes I / II
If yes, name of pacer clinic: _____		<input type="checkbox"/> Family History <input type="checkbox"/> Hyperlipidemia
Previous CVA <input type="checkbox"/> No <input type="checkbox"/> Yes	Pulmonary Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Smoking
Peripheral Vascular Disease <input type="checkbox"/> No <input type="checkbox"/> Yes	Myocardial Infarction <input type="checkbox"/> No <input type="checkbox"/> Yes	
Heart Failure <input type="checkbox"/> No <input type="checkbox"/> Yes	Atrial Fibrillation/Other arrhythmias <input type="checkbox"/> No <input type="checkbox"/> Yes	

**SAFE TO PARTICIPATE IN WARM THERAPEUTIC POOL (HYDROTHERAPY) IF THERAPIST INDICATES THIS IS NECESSARY?**  No  Yes

**HAS THE MINISTRY OF TRANSPORTATION BEEN NOTIFIED OF PATIENT'S MEDICAL STATUS?**  No  Yes

**REFERRING PHYSICIAN:** I authorize a referral for this individual for the services specified.

Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (yyyy/mm/dd)  
 Billing No. (if available): \_\_\_\_\_ Hospital: \_\_\_\_\_

**SECTION 5: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION**

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager)

I agree that \_\_\_\_\_ may release my personal health information to make a referral.  
(Referral source disclosing information)

**Organization(s) referred to:**

- |   |  |  |                        |
|---|--|--|------------------------|
| <input type="checkbox"/> Baycrest                     | <input type="checkbox"/> North York General Hospital       | <input type="checkbox"/> The Scarborough Hospital    | Other (specify): _____ |
| <input type="checkbox"/> Bridgepoint Health           | <input type="checkbox"/> Rouge Valley Health System        | <input type="checkbox"/> Toronto Rehab/UHN           |                        |
| <input type="checkbox"/> Credit Valley Hospital       | <input type="checkbox"/> Southlake Regional Health Centre  | <input type="checkbox"/> Trillium Health Centre      |                        |
| <input type="checkbox"/> Halton Healthcare Services   | <input type="checkbox"/> St. John's Rehab Hospital         | <input type="checkbox"/> University Health Network   |                        |
| <input type="checkbox"/> Lakeridge Health             | <input type="checkbox"/> St. Joseph's Health Centre        | <input type="checkbox"/> West Park Healthcare Centre |                        |
| <input type="checkbox"/> Markham Stouffville Hospital | <input type="checkbox"/> Sunnybrook Health Sciences Centre | <input type="checkbox"/> York Central Hospital       |                        |

**To be completed for all referrals:**

Print Name of Patient: \_\_\_\_\_

Signature of Patient/Substitute: \_\_\_\_\_

If unable to obtain signature, has verbal consent been obtained?  Yes

Witness: \_\_\_\_\_

(Print name)

\_\_\_\_\_  
(Signature)

Name of Substitute: (Print name) \_\_\_\_\_

Relationship to patient, if signed by Substitute: \_\_\_\_\_

- Yes, an interpreter was used when consent was obtained.
- No interpreter was required.

Date:(YYYY/MM/DD)\_\_\_\_\_