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](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](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](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](http://www.gtarehabnetwork.ca/outpatient-ambulatory).

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December 2011
## OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

### SECTION 1: DEMOGRAPHIC INFORMATION

**PATIENT'S NAME:** ____________________________

<table>
<thead>
<tr>
<th>GENDER</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB</td>
<td></td>
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</tbody>
</table>

**HOME ADDRESS**

- Home Telephone Number:
- Alternate Phone Number:

**HEALTH CARD NUMBER**

- Version:
- Expiry Date (If available):

Province/Territory issuing Health Card:

- Ontario
- Country/Province #:
- Other (Specify):

**RESPONSIBILITY FOR PAYMENT (IF NOT OHIP)**

- Private Insurer
- WSIB
- Auto Insurance
- Veteran
- Self Pay
- IFH (Interim Federal Health Grant)
- Out of Province

**SPEAKS, UNDERSTANDS ENGLISH**

- Yes
- Minimal
- No

If Minimal/No, is family interpreter available?

- Yes
- No

If no, interpreter is needed for what language?

**SUBSTITUTE DECISION MAKER (SDM) / POWER OF ATTORNEY (POA) / EMERGENCY CONTACT INFORMATION**

- Name:
- Daytime Tel. No.
- Relationship to Client:

**PRIMARY CONTACT TO ARRANGE APPOINTMENTS:**

- Client
- SDM/POA
- Emergency Contact

Provide name and daytime telephone if different from client or individual listed above

**FAMILY PHYSICIAN’S CONTACT INFORMATION:**

- No Family Physician

- Name:
- Phone:
- Fax:
- Address:
- Billing No. (if available):

### SECTION 2: REFERRAL INFORMATION

**REFERRAL DATE:** ____________/__________/_________ (YYYY/MM/DD)

**REFERRAL CONTACT**

- Contact name/position:
- Phone: ( )
- Pager: ( )

**Organization & Program/Service:** ____________________________

**CLIENT IS CURRENTLY:**

- at home
- other (specify)

**IF CLIENT IS IN HOSPITAL:**

- Date of Admission: _____ / _____ / _____ (YYYY/MM/DD)
- Planned Date of Discharge: _____ / _____ / _____ (YYYY/MM/DD)

**PRIMARY DIAGNOSIS:**

- ABI
- Amputee
- Burns
- Cardiac
- General/Medical
- Geriatric
- MSK
- Neuro
- Oncology
- Pulmonary
- Spinal Cord
- Trauma
- Transplant
- Other

**REHAB SERVICE(S) REQUESTED:**

- Note: Not all organizations provide all services listed below. For detailed information about programs offered by specific organizations, please refer to Rehab Finder at [http://www.gtarehabnetwork.ca/find-rehab-programs](http://www.gtarehabnetwork.ca/find-rehab-programs) or contact the organization directly.

- Occupational Therapy
- Physiotherapy
- Dietician
- Social Work
- Nursing
- Psychiatry
- Psychology
- Therapeutic Recreation
- Speech Language Pathology / Swallowing
- Speech Language Pathology/ Communication
- Psychiatry
- Other rehab services required (e.g. Seating Clinic, Vocational Rehab, Pain Management Clinic, Augmentative Communication/Writing Clinic etc.)

**SPECIAL CONSIDERATIONS:**

- E.G. HOUSING, TRANSPORTATION, SOCIAL SUPPORT, VISUAL IMPAIRMENT, OTHER IDENTIFIED RISKS

(If available, attach Social Work report)

**IS CLIENT CURRENTLY RECEIVING OTHER REHAB SERVICES?**

- No
- Yes (specify)

**REPORTS ATTACHED?**

- (e.g. CT scan, OT/PT/SLP/SW notes etc.)
- Yes
- No
**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)

- [ ] Independent
- [ ] Assistance
- [ ] Supervision

Mobility Aid: __________________________

### 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:** ____________________________
### SECTION 4: RELEVANT MEDICAL INFORMATION

**To be completed by Physician or Physician Designate**

<table>
<thead>
<tr>
<th>ALLERGIES:</th>
<th>□ No</th>
<th>□ Yes (list):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PRIMARY DIAGNOSIS &amp; HISTORY OF PRESENTING ILLNESS (relevant to reason for referral):</th>
<th>Date of Injury/Onset: ______________ yyyy/mm/dd</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PAST MEDICAL / SURGICAL HISTORY (relevant to rehab referral):</th>
<th>Date of Surgery: ______________ yyyy/mm/dd</th>
</tr>
</thead>
</table>

**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)

<table>
<thead>
<tr>
<th>RELEVANT MENTAL HEALTH HISTORY:</th>
<th>□ No □ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, describe history, current status including suicide risk, provide recent consult notes and details of follow-up arrangements:</td>
<td></td>
</tr>
</tbody>
</table>

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

**INFECTION DISEASE:**

- □ No □ Yes (specify below) □ Unknown
- MRSA: □ No □ Yes Location: ______________________
- VRE: □ No □ Yes Location: ______________________
- C-Difficile: □ No □ Yes Other(specify): ______________________

<table>
<thead>
<tr>
<th>WEIGHT BEARING STATUS AS ORDERED BY MD:</th>
<th>□ No restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left: □ Right: □ As tolerated □ Partial ________% □ Touch weight bearing □ Non weight bearing</td>
<td></td>
</tr>
<tr>
<td>Precautions and restrictions: ______________________</td>
<td></td>
</tr>
<tr>
<td>Date to become weight bearing: ________________</td>
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</tr>
</tbody>
</table>

**CARDIOVASCULAR & PULMONARY HISTORY:**

- □ None known

<table>
<thead>
<tr>
<th>Pacemaker/ICD</th>
<th>□ No □ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>If yes, name of pacer clinic: ______________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Previous CVA</th>
<th>□ No □ Yes</th>
<th>Pulmonary Disease</th>
<th>□ No □ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Peripheral Vascular Disease</th>
<th>□ No □ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Heart Failure</th>
<th>□ No □ Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Atrial Fibrillation/Other arrhythmias</th>
<th>□ No □ Yes</th>
</tr>
</thead>
</table>

**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:

☐ Baycrest  ☐ North York General Hospital  ☐ The Scarborough Hospital  Other (specify): _______
☐ Bridgepoint Health  ☐ Rouge Valley Health System  ☐ Toronto Rehab/UHN
☐ Credit Valley Hospital  ☐ Southlake Regional Health Centre  ☐ Trillium Health Centre
☐ Halton Healthcare Services  ☐ St. John’s Rehab Hospital  ☐ University Health Network
☐ Lakeridge Health  ☐ St. Joseph’s Health Centre  ☐ West Park Healthcare Centre
☐ Markham Stouffville Hospital  ☐ Sunnybrook Health Sciences Centre  ☐ 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) __________________________