UHN West Park Healthcare Centre

170 Emmett Avenue, 2nd Floor
Toronto, ON M6M 2J5
Tel: 416-243-3640 ext 2
Fax: 416-243-1177
Outpatientclinic@uhn.ca

WEST PARK AMPUTEE / ORTHOTIC CLINIC REFERRAL FORM

INCOMPLETE REFERRALS WILL NOT BE PROCESSED AND WILL BE RETURNED

APPLICATIONS MUST INCLUDE ALL SECTIONS OF THIS FORM TO BE COMPLETED ALONG WITH CURRENT MEDICATION LIST AND SUPPORTING MEDICAL DOCUMENTATION AS PART OF YOUR REFERRAL PACKAGE

PATIENT DEMOGRAPHICS:

Name: _____ Date of Birth: _____
(Last, First) YYYY/MM/DD

Health card number: _____ Version Code: _____ Gender: _____

Address: _____
(Street Name, City, Province, Postal Code)

Contact Number: _____ Alternate: _____

Email Address: _____

Language Spoken: _____ Is an Interpreter required: Yes ____ No ____

Is the injury work or motor vehicle accident related? Yes ____ No ____

If yes, Claim Organization: _____ Claim # _____

REFERRING PHYSICIAN / NURSE PRACTICIONER INFORMATION:

Physician / NP Name: _____ Billing # _____ CPSO # _____

Telephone: _____ Fax: _____

Address: _____

Family MD/ NP name: _____ Tel # _____

UHN West Park Healthcare Centre

170 Emmett Avenue, 2nd Floor
Toronto, ON M6M 2J5
Tel: 416-243-3640 ext 2
Fax: 416-243-1177
Outpatientclinic@uhn.ca

FAMILY / CAREGIVER INFORMATION:

Name: _____ Relationship: _____

Contact Number: _____ Email: _____

Does the patient have a POA? Yes ____ No ____ Name: _____

If yes, is the POA in charge of the following: Finances ____ Personal Care ____

CURRENT STATUS

Date of amputation: _____ Hospital: _____

Name of Surgeon: _____

Level of amputation: Below Knee ___ Above Knee ___ Below Elbow ___ Above Elbow ___

Partial hand ___ Fingers ___ Partial foot ___ Toes ___

Side of amputation: Left ____ Right ____ If fingers/toes, list digits: _____

Does the patient currently have any open wounds: Yes ____ No ____

If yes- Please describe wound, healing status and size: _____

_____

_____

_____

REASON FOR REFERRAL

_____

_____

_____

REHAB GOALS / MOST PROBLEMATIC ISSUES AFFECTING FUNCTION

1. _____
2. _____

UHN West Park Healthcare Centre

170 Emmett Avenue, 2nd Floor
Toronto, ON M6M 2J5
Tel: 416-243-3640 ext 2
Fax: 416-243-1177
Outpatientclinic@uhn.ca

RELEVANT MEDICAL HISTORY:

_____

_____

_____

_____

Primary Diagnosis: _____

Date of onset: _____

Weight bearing status: WBAT ____ PWB ____ NWB ____ Other _____

Presently in hospital: Yes ____ No ____ If yes-Discharge date: _____

Does the patient have diabetes: Yes ____ No ____ If yes, Type: _____

Visual Impairment: Yes ____ No ____

Hearing Impairment: Yes: ____ No ____

Living Arrangements: With Family _____ With others ____ Alone ____

Does the patient have a good support system? Yes ____ No ____

1. Any known risk to self or others? Yes____ No____
(i.e. aggression, substance abuse, mental health concerns)

2. Does the patient have a history of falls? Yes ____ No ____

3. Does the patient Current have wounds/Infection Yes ____ No____

If yes to questions 1-3 above, please comment: _____

_____

_____

_____

_____

_____

Referring Physician/ NP Signature: _____ Date: _____