UHN Toronto Rehabilitation Institute

CIOR Complex Injury Outpatient Rehabilitation

Complex Injury Outpatient Rehabilitation
Referral Form

Client Name: _____ _____
(Last / First)

Male: ☐ **Female:** ☐ **Date of Birth:** _____ / _____ / _____
year month day

Health Card No.: _____ **Version** (*if any*)**:** _____

Home Address: _____

Postal Code: _____ **Telephone: (** **)**_____

Alternate Contact: _____ **Telephone: (** **)**_____
(Name and Relation)

Insurance : ☐ **WSIB** ☐ **MVA** ☐ **Other** **Claim #:** _____

Contact: _____ **Telephone:** ( )_____

_____ **Fax:** _____

Date of Injury/Event: _____ / _____ / _____
year month day

Diagnosis: _____

Brief Description of Injury: _____

_____

_____

_____

_____

Service Requested:

Specify Program and Site: ☐ UC-ABI ☐ HC-MSK ☐ Other: _____

Select service(s) requested: ☐ PT ☐ OT ☐ SLP ☐ SW ☐ Psychology ☐ Nursing ☐ Other: _____

☐ Neuropsychology ☐ Interpreter required Language: _____

Referring Physician or Source:

Name/position: _____

Organization: _____

Address: _____

Phone: ( )_____

Fax: ( )_____

Billing #: _____

Family Physician:

Name: _____

Address: _____

Phone: ( )_____

Fax: ( )_____

Billing #: _____

Reports Included:

☐ MRI ☐ OT Report ☐ Consult Note ☐ Discharge Note

☐ CT Scan ☐ PT Report ☐ Speech Language Pathology Report

☐ X-ray ☐ Social Work Report ☐ Other: _____

This page completed by: _____ _____ _____ / _____ / _____
print name *signature* *year month day*

UHN Toronto Rehabilitation Institute

Client Name: _____

Professionals/Agencies currently involved:

Adjuster/Adjudicator: Company: _____ Contact: _____ Phone: ( )_____

Case Manager: Company: _____ Contact: _____ Phone: ( )_____

Lawyer: Firm: _____ Contact: _____ Phone: ( )_____

Other: Company: _____ Contact: _____ Phone: ( )_____

Current Medical Consultants and Therapists:

Contact Name	Discipline	Phone

PRESENTING SYMPTOMS

PHYSICAL ISSUES:	NON-ISSUE	ISSUE	Comments (IDENTIFY RISK ISSUES)
Paresis/paralysis:	☐	☐	
Mobility:	☐	☐	
Balance:	☐	☐	
Pain:	☐	☐	
Headaches:	☐	☐	
Fatigue:	☐	☐	
Dizziness:	☐	☐	
Sleep disturbances:	☐	☐	
Medication management:	☐	☐	

PSYCHOSOCIAL/ BEHAVIOURAL ISSUES:	NON-ISSUE	ISSUE	Comments (IDENTIFY RISK ISSUES)
Impulse control:	☐	☐	
Mood disorder:	☐	☐	
Thought disorder:	☐	☐	
Aggressiveness:	☐	☐	
Sexually inappropriate:	☐	☐	
Suicidal risk:	☐	☐	

COGNITIVE STATUS:	NOT TESTED	INTACT	IMPAIRED	Comments (IDENTIFY RISK ISSUES)
Orientation:	☐	☐	☐	
Motivation/initiation:	☐	☐	☐	
Judgment:	☐	☐	☐	
Memory (short term):	☐	☐	☐	
Memory (long term):	☐	☐	☐	
Attention:	☐	☐	☐	
Frustration tolerance:	☐	☐	☐	
Insight:	☐	☐	☐	
Perception:	☐	☐	☐	
Reasoning/problem solving:	☐	☐	☐	
Executive Functioning:	☐	☐	☐	
Communication/Language:	☐	☐	☐	

This page completed by: _____ _____ _____ / _____ / _____

print name *signature* *year* *month* *day*

FAX COMPLETED APPLICATION TO: (416) 597- 7164

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www.torontorehab.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PERSONAL HEALTH INFORMATION

I hereby authorize _____

name of facility/agency releasing information

to release personal health information in my medical/clinical records

_____ _____

name of patient/client

to: Complex Injury Outpatient Rehab Program and

_____

names of institution(s)/agency(s) requesting information

_____

_____

_____

I understand that this information is to be used by the recipient(s) for the purpose of facilitating treatment.

Expiration Date of Authorization: _____ / _____ / _____
year *month* *day*

_____

print name

_____ Date: _____ / _____ / _____

signature *year* *month* *day*

Relationship if signed by other than the patient/client: _____

Witness:

_____

print name

_____ Date: _____ / _____ / _____

signature *year* *month* *day*