The Kite Research Institute UHN

KITE Innovations and Rehabilitation Clinics

Referral Form. Fax to 416-597-7111

Please select preferred location? ☐ Lyndhurst Centre ☐ University Centre ☐ No preference

☐ Research - see website for list of current studies and labs (no fee)

Client Name: _____ _____
Last name *First name*

Date of Birth: _____ / _____ / _____
year *month* *day*

Health Card #: _____ **UHN-MRN #** (if applicable): _____

Home Address: _____

_____

Telephone 1: _____ **Telephone 2:** _____ _____

Alternate Contact Name and Telephone: _____

Purpose of Referral: _____

Please select ALL that apply to the client's needs (see website for program details):

☐ Neuro-Rehabilitation with or without Neuro-modulation (non-invasive electrical stimulation)

- ☐ Gait and Balance Rehabilitation
- ☐ Upper Extremity Rehabilitation
- ☐ Drainage Management
- ☐ Self-Management/Independent Home Program
- ☐ Fitness Training (Aerobic, Strength)
- ☐ Upper Extremity Group Program
- ☐ Custom splinting

☐ Degenerative Cervical Myelopathy (DCM) Program (if selecting DCM program also complete DCM referral form) *Fax Attn to: Dr. Sukhvinder Kalsi-Ryan*

☐ Virtual Programs

- ☐ Virtual Neuro-Rehabilitation with a Registered Clinician
- ☐ Together in Movement and Exercise at Home (TIME @ home)™

Referring Individual:	_____	Family Physician:	_____
Phone:	_____	Phone:	_____
Fax:	_____	Fax:	_____
Billing # (if applicable):	_____	Billing #:	_____
Address:	_____	Address:	_____
	_____		_____
Signature:	_____	Signature:	_____

Any medical contraindication to providing neuro-rehabilitation for this client?

☐ NO ☐ Not Sure ☐ YES (please specify): _____

Any medical contraindications to receiving Functional Electrical Stimulation (FES) or Neuromodulation?

☐ NO ☐ YES*

***To expedite referral and enable the client to be seen as soon as possible at KITE Clinics, a physician may complete the contraindications checklist at the end of the referral;**

***If a physician signature cannot be secured, please complete and fax the referral. KITE Clinics will secure the most appropriate physician signature from the client's circle of care prior to using FES or Neuromodulation.**

Diagnosis/HPI: _____

_____

_____

_____

Date and Type of Surgery (if applicable): _____

_____

Relevant medical history: _____

_____

_____

_____

List of Medications (or attach medical record): _____

_____

_____

_____

Other relevant information: _____

_____

_____

_____

Please indicate what additional reports or diagnostic tests are attached:

☐ MRI Report	☐ CT Scan	☐ PT Report	☐ OT Report	☐ Consult note
☐ X-ray	☐ Discharge note	☐ ECG report	☐ ECHO	☐ Other: _____

Your client, _____, is being considered for therapy using non-invasive electrical stimulation (ES) at KITE Clinics. These devices have multiple channels that deliver low energy electrical pulses transcutaneously via surface electrodes to facilitate muscle or nerve stimulation. All devices are approved by Health Canada.

PLEASE CHECK BOXES BELOW FOR ANY RESTRICTIONS IN USING ES (MyndMove™)

☐ **NO RESTRICTIONS**

- **Client is medically cleared to use non-invasive electrical stimulation with no additional precautions or other specific considerations.**

CONTRAINDICATIONS:

☐ Pacemaker, implantable defibrillator, or an implanted neurostimulation device

☐ Metallic implants where the electrical stimulation may be delivered:

☐ upper extremity ☐ mid to upper back ☐ scapular region

☐ Cardiac conditions

☐ known arrhythmia ☐ other (please specify): _____

☐ Epilepsy

☐ Seizures → well controlled? → ☐ YES (proceed with ES)

→ ☐ NO (**DO NOT** use ES)

☐ Special conditions in area of affected upper limb

☐ cancerous lesions ☐ phlebitis ☐ thrombophlebitis

☐ varicose veins ☐ open wounds ☐ unhealed fracture

PRECAUTIONS:

☐ Botulinum Toxin administered in the affected upper limb over the last 3 months

- **precaution:** please avoid end-range/extreme joint ranges

☐ Contractures

☐ fingers ☐ hand ☐ elbow ☐ shoulder ☐ neck ☐ other _____

☐ Impaired sensation

NOTE: Please share any specific considerations that are not covered above.

_____

_____

Physician Signature: _____ Date: _____