MULTIPLE SCLEROSIS OUTPATIENT SERVICES REFERRAL

Toronto Rehab – Rumsey Centre Neuro, 345 Rumsey Rd, Toronto, ON M4G 1R7
Phone: 416-597-3422 x 5300 (reception) Fax: 416-597-7160

Admission Criteria *(please check)*:

- ☐ Confirmed diagnosis of Multiple Sclerosis or Neuromyelitis Optica (NMO) Spectrum Disorder
- ☐ **Have an EDSS score of 4.0 to 7.0**
- ☐ Have active rehabilitation goals that are attainable within 6 weeks
- ☐ Demonstrates sufficient cognitive skills to be able to integrate new learning
- ☐ **Require 2 or more allied health services (OT, PT, SLP, Social Work)**
- ☐ Be medically stable and motivated to regularly attend & participate in therapy for at least 1 hour per day
- ☐ Be able to secure reliable transportation to/from outpatient appointments
- ☐ Be independently mobile, or have someone to assist in attending appointments within the facility
- ☐ Be independent in toileting or bring attendant care
- ☐ **Fax most recent consultation note**

Please fax this referral form, consult reports and MRI to the attention of the "MS Service Coordinator"

EDSS Score: _____ **Your referral will NOT be processed WITHOUT an EDSS score.**

CONFIRMED DIAGNOSIS OF MS: ☐ Yes ☐ No Date of MS Diagnosis _____

☐ Relapsing-remitting ☐ Primary Progressive ☐ Secondary Progressive ☐ Unknown/Other

Patient's Name: (Last) _____ (First) _____

Date of Birth (m/d/y) _____ Gender: ☐ M ☐ F ☐ Other

Address: _____
(Street) (Apt. #) (City) (Postal Code)

Telephone #: _____ Alternate Telephone #: _____

Ontario Health Card #: _____ Version Code _____

Please confirm that the patient has a reliable means of transportation to Rumsey Centre: ☐ Yes ☐ No

Primary Language spoken: _____ Secondary Languages spoken: _____

Interpreter Needed? ☐ Yes ☐ No

PRIMARY CONTACT TO ARRANGE APPOINTMENTS: ☐ Patient ☐ Other: _____

☐ Patient consents to liaison with PRIMARY CONTACT about this referral

OTHER SIGNIFICANT MEDICAL CONDITIONS:

Cardio-Respiratory: ☐ Previous MI ☐ Heart failure ☐ Hypertension ☐ COPD/Asthma

Diabetes Mellitus: ☐ Yes ☐ No Details: _____

Mental Health: ☐ Yes ☐ No Details: _____

Substance Use: ☐ Yes ☐ No Details: _____

Behaviour Concerns: ☐ Yes ☐ No Details: _____

Seizure Disorder: ☐ Yes ☐ No Free of seizures for at least 6 months: ☐ Yes ☐ No

Other medical conditions: _____

Allergies (including food): _____

turn over ➔

FUNCTIONAL STATUS:

History of Falls? ☐ No ☐ Yes Details: _____

Mobility Aid: ☐ None ☐ Cane ☐ Rollator/Walker ☐ Wheelchair ☐ Scooter

Does this patient require assistance with Toileting? ☐ No ☐ Yes, assistance will be provided by: _____

Transfers: ☐ Independent ☐ Supervision ☐ 1 person ☐ 2 person

Any other safety concerns: ☐ No ☐ Yes Details: _____

CHECK SERVICES REQUESTED:

☐ Physiatry
☐ Occupational Therapy (OT)
☐ Physiotherapy (PT)
☐ Social Work (SW)
☐ Speech-Language Pathology (SLP)

*Please identify **2 or more** allied health services (OT, PT, SW, SLP) for admission to our program*

Please note, patients may be seen for 1:1 PT as well as group therapy.

If the patient needs to see the ***physiatrist ONLY***, check here*:*** ☐

GOALS IDENTIFIED to address in our active MS rehab program:

☐ Physical – lower extremity (mobility, ambulation, balance/falls risk, gait aids)
☐ Physical – upper extremity (gross/fine motor movement)
☐ Cognition
☐ Visual perception
☐ Personal care
☐ Activities of Daily Living (e.g., cooking, housekeeping, shopping, money management, driving)
☐ Communication
☐ Swallowing
☐ Emotional or Behavioural Wellbeing
☐ Sleep
☐ Pain
☐ Productivity (e.g., work, school, volunteering)

☐ Other: _____

☐ **Patient consents to referral to MS Outpatient Services at Toronto Rehab Rumsey Centre Neuro**

REFERRING PHYSICIAN / REFERRAL SOURCE:

Name:_____

Address: _____

_____

Phone: _____

Fax: _____

FAMILY PHYSICIAN:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

Referring Physician's Signature: _____ **Billing #:**_____

Date: _____