COMMUNITY STROKE AND NEUROLOGICAL REHABILITATION PROGRAM
St. Joseph's Health Care London

PHONE: 519-685-4000 ext.44803 (Community) ext.44578 (Outpatient) **FAX:** 519-685-4802
MAILING ADDRESS: Parkwood Institute, Main Building, P.O. Box 5777, STN B, London, ON N6A 4V2

Service Being Requested			
Community Team ☐ Outpatient Team ☐			
CLIENT INFORMATION: (Required)			
Last name:	First name:	Date of birth: *(YYY/MM/DD)*	Gender:
Address:	City, province:	Phone number:	
Health card (including version code):		Is an interpreter required? Yes ☐ No ☐ Can family/friend interpret? Yes ☐ No ☐ Language:	
Family physician: *(Full Name/CPSO - if available)*			
Client has consented to the referral? Yes ☐ No ☐		If 'No', consent obtained from: *(Name/relationship)*	
ALTERNATE CONTACT INFORMATION: (Required)			
Name:	Relationship to client:	Phone number:	Contact for initial scheduling: ☐ Consent obtained from patient: Yes ☐
CURRENT STATUS: (Required)			
Primary diagnosis: *(If stroke, specify if hemorrhagic or ischemic)*		Date of injury: *(YYYY/MM/DD)*	
Client current location: Acute hospital: ☐ Rehab unit ☐ Home ☐ Other ☐			
Expected date of discharge: (YYYY/MM/DD) Expected discharge destination: Retirement home ☐ Home ☐ Other ☐ Please describe, if different from address above:			
REASON FOR REFERRAL (Required):			
Presenting difficulties: ☐ Walking, balance, leg movement or getting around ☐ Arms and hand function ☐ Everyday self-care activities (e.g. dressing, grooming, eating) ☐ Speaking, understanding, reading, expressing thought ☐ Swallowing, eating or drinking		☐ Medication management ☐ Returning to leisure activities, hobbies ☐ Returning to work or school ☐ Managing emotional changes ☐ Caregiver burnout (need to education and strategies) ☐ Self-managing	

Please outline specific, measurable, attainable, realistic, timely goals:

Home safety concerns:

☐ High falls risk (1-2 falls in last week) ☐ Risk of choking ☐ Suicidal ideations ☐ Lives alone with no supports

Status of Driver's License:

☐ Valid ☐ Suspended ☐ Letter sent to MTO ☐ Unknown

ACTIVE COMMUNITY REFERRALS: (Please check off all the community agencies with whom the patient has been linked)

☐ Paratransit	☐ Seniors WrapAround
☐ Dale Brain Injury	☐ Canadian Mental Health Association
☐ March of Dimes	☐ LHSC to home
☐ Ontario Health atHome, specify:	☐ Other: *(please list)*

RELEVANT MEDICAL HISTORY (e.g. MRSA, dementia, cancer, dialysis, substance abuse, allergies)

TO EXPEDITE THIS REFERRAL:

1. Complete the referral form in its entirety
2. Include all relevant medical history, medication, consult notes, CTs and MRIs, if available
3. Provide list of medications and allergies, if available

☐ **Patient consents to medical chart review to confirm eligibility.**

REFERRAL SOURCE INFORMATION

Print name of referral source	Physician/nurse practitioner signature *(Not required if referring to CSRT)*	
Phone:	Fax:	Date of referral:

WHAT HAPPENS NEXT?

- Referrals are reviewed to determine initial eligibility. If not eligible, the referring provider and family physician (if available) will be notified, and alternative services may be recommended.
- If appropriate, the client will be contacted to schedule an intake screening to further assess needs and program fit.
- Please note that referrals may be transitioned between community and outpatient teams based on the client's presentation and goals.
- To ensure the client receives the optimal level of care/service, other programs may be determined more suitable. You will be informed if the client is referred to a different program.