

## Referral Form

**Office Use Only:**
**Date Referral**
**Received:** \_\_\_\_\_

**ID#:** \_\_\_\_\_

**Thames Valley**

T. 519-685-4292 x 45034

F. 519-685-4802

Elgin Oxford Middlesex SW Norfolk

**Huron-Perth**

T. 519-527-8425

F. 519-272-8242

**Grey-Bruce**

T. 519-376-2121 x 2584

F. 519-378-1550

**Client Information:**

Name:		Health Card #:	Registration #:
Address:		City/Town:	Postal Code:
Phone:	Date of Birth (yy/mm/dd):		Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Common-law <input type="checkbox"/> Widow(er)			
Work Status: <input type="checkbox"/> retired <input type="checkbox"/> working <input type="checkbox"/> other			
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (please indicate):			
Next of Kin:		Telephone:	Relationship:
Alternate Contact Information:		Email Address:	

**Current Status:**

Has the client been informed and consents to referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is client currently in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No	Facility:
Admission to Hospital (yy/mm/dd):	Admission FIM (if available):
Expected Date of Discharge (yy/mm/dd):	Discharge FIM (if available):
Have you attached any relevant reports/discharge summaries? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> will forward later	
Expected Discharge Destination: <input type="checkbox"/> Home <input type="checkbox"/> LTC <input type="checkbox"/> Other (If other please describe):	
Status of Driver's License: <input type="checkbox"/> valid <input type="checkbox"/> suspended <input type="checkbox"/> letter sent to MTO by physician <input type="checkbox"/> unknown	

**Physician Information:**

Attending Physician Name:	Phone:
Family Physician Name:	Phone:
Physician Signature (optional):	

**History:**

Date of stroke: (yy/mm/dd)	Type of stroke (if known or for assistance, please ask your health care provider): <input type="checkbox"/> Ischaemic (clot) <input type="checkbox"/> Hemorrhagic (bleed) <input type="checkbox"/> Not known	Diet: Does client follow a special diet? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Weight Loss/Gain <input type="checkbox"/> Diabetic <input type="checkbox"/> Modified Texture (i.e., pureed, minced, thick fluids) <input type="checkbox"/> Other:
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**Presenting Difficulties (What areas are you having difficulty with? Please check all that apply.):**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> difficulty with arm and hand function      | <input type="checkbox"/> eating well and preparing meals        | <input type="checkbox"/> impulsiveness                            |
| <input type="checkbox"/> difficulty with walking and getting around | <input type="checkbox"/> household tasks                        | <input type="checkbox"/> fatigue                                  |
| <input type="checkbox"/> difficulty with vision and perception      | <input type="checkbox"/> difficulty swallowing                  | <input type="checkbox"/> difficulty with memory                   |
| <input type="checkbox"/> talking and understanding                  | <input type="checkbox"/> safety in the home                     | <input type="checkbox"/> boredom                                  |
| <input type="checkbox"/> taking care of myself                      | <input type="checkbox"/> adjusting to life after stroke         | <input type="checkbox"/> learn ways to improve my quality of life |
| <input type="checkbox"/> support to care for my loved one           | <input type="checkbox"/> managing emotional changes             |   |
| <input type="checkbox"/> concerned about my finances                | <input type="checkbox"/> learn more about my stroke             |   |
| <input type="checkbox"/> learn more about community resources       | <input type="checkbox"/> learn to reduce risk of another stroke |   |
| <input type="checkbox"/> other: _____                               |   |   |

**Priorities for service: (in the client's own words where possible)**

Based on the difficulties listed above, I want to improve in these top 3 areas (rehab goals):

- 1.
- 2.
- 3.

Is there anything else you think we should be aware of?

**Relevant Medical/Psychiatric History** (MRSA, Alzheimer's, Parkinson's, Dementia...) Attach Medication List if available:

Reaction to Medication ☐Y ☐N:  
If yes please describe:

Latex or Environmental Reaction ☐Y ☐N:

**Is there a history of:** ☐ Substance use ☐ Criminal offences or charges  
please describe:

**Referral Information:**

Date of referral : (yy/mm/dd) **Referral Source:** (Name of Person filling out the form - indicate agency if applicable)

**Currently involved with Ontario Health atHome?:** ☐Y ☐N **Please Specify and Indicate Name Contact Number(s):**

**Other agencies/services?** (i.e., adult day programs, privately paid therapies, transportation services...):