

Regional Acquired Brain Injury Outpatient Services



Physiatry Referral Form

Parkwood Institute, Main Building

P.O. Box 5777, Station B

London, Ontario, N6A 4V2

Phone 519-685-4064 Toll Free: 1-866-484-0445

Fax: 519-685-4824

Referral Date:	Date Referral Received:	Parkwood Institute MR#:
PATIENT'S PERSONAL INFORMATION: (Place sticker here)		
Last Name:	First Name:	<input type="checkbox"/> Male <input type="checkbox"/> Female
Birth Date: (day/month/year)	Age:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced
Address- Street:	City:	Province:
Postal Code:	Telephone: (Home)	Telephone: (Other)
E-mail:	Health Card #:	
REASON FOR REFERRAL:		
MEDICAL INFORMATION:		
Date of Injury/onset: (day/month/year)	<input type="checkbox"/> Traumatic	<input type="checkbox"/> Non-Traumatic
	GCS Score: _____	LOC: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cause of Brain Injury:		
<input type="checkbox"/> Fall	<input type="checkbox"/> Falling object/From an object	<input type="checkbox"/> Assault
<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Motor Vehicle Accident (MVA)	<input type="checkbox"/> CVA (Stroke/Aneurysm)
<input type="checkbox"/> Workplace Injury	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Anoxia
		<input type="checkbox"/> Tumour
Has there been 3 rd party funding? <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Private Insurer <input type="checkbox"/> WSIB <input type="checkbox"/> Other: _____		
Please attach relevant medical records of ABI:		
Additional Records Faxed with Referral <input type="checkbox"/> Yes		
<input type="checkbox"/> CT/MRI of Head	<input type="checkbox"/> C-Spine Imaging	<input type="checkbox"/> Emergency/Operative/Consultation Notes
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Social Work
	<input type="checkbox"/> SLP	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Criminal offences or charges <input type="checkbox"/> Violent Behaviour <input type="checkbox"/> Substance Use <input type="checkbox"/> Mental Health Illness		
If yes, please describe: _____		

FAX REFERRAL - DATE: (dd/mm/yyyy) _____ (ABI Outpatient Referral)

Last Name: _____ First Name _____

Date of Birth: _____ Age: _____ HIN# _____

History of Seizure: Yes No

Allergies: No Yes (list) _____

Current Medications: (Include prescription and non-prescription medications)

Medication	Dose (include units)	Route	Frequency	Prescribed by

Medication List Complete: Yes No → **Additional List Faxed with Referral?** Yes

Relevant medications previously trialed: _____

PAST MEDICAL HISTORY/ISSUES: None Identified

Have any therapies or treatments been received since the brain injury? Yes No

If yes, what therapies/services have been received? Physiotherapy Occupational Therapy
 Massage Acupuncture Social Work Audiologist Optometrist
 Speech Language Pathology Other: _____

Is there anything else we should be aware of? _____

REFERRING PHYSICIAN (Place sticker here)

Printed Name: _____ Signature: _____

Phone: _____ Fax: _____

WHAT HAPPENS NEXT?

We will contact you within 7 business days to confirm receipt of your referral and to request missing information. You will receive a notification of the triage decision. **To expedite this process, please ensure that you have provided all requested clinical information and contact information with this referral.**