Comprehensive Outpatient Rehabilitation Program

Parkwood Institute, Arthur J. Hobbins Building
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Referral Form

FOR OFFICE USE ONLY	
Referral Date:	MR#:
Contact Date:	Intake Date:

CLIENT INFORMATION			
Name:	DOB (YY/MM/DD):		
Address:		Postal Code:	
Phone#:	Alternate Phone#:		
Health Card Number :		Version Code:	
Next of Kin or Alternate Contact:		Phone #:	
Relationship to Client:			
Does patient consent to referral? Yes □ No □			
Employment Status: Unemployed □ Retired □ Working □			
Preferred Language: □ English □ French □ Other (please indicate) :			

DRIVING INFORMATION
DRIVING: Please discuss any medical/functional concerns with the patient before submitting this referral.
Has the Ministry of Transportation been informed the patient has a medical condition that may affect their ability to drive? □ Yes □ No □ Uncertain
Will transportation to CORP be an issue? □ Yes □ No □ Paratransit □ Family

PHYSICIAN INFORMATION				
Family Physician:			Tel #:	
Referring Physician:			Tel #:	
Expected Discharge Date *(if currently in hospital)*:				
Physician Signature (Required):				
Referral Source:	Acute Care Hospital □	Rehab Unit □	Family Physician □	Specialist (phys) □
	Long-Term Care □	SW LHIN □	Other □	
Name of person filling out this form:			Tel #:	

Client Name: _____MR#: _____

REFERRAL INFORMATION

Referring Diagnosis:	Date of Onset:

Relevant Medical History (include if Hx seizures, dementia, addictions, or mental health, etc.): □ **See attached**

Infection Control: MRSA □ VRE□ CDIFF□ OTHER□ **Allergies:**

Medications/Dosages: □ **See attached**

Have referrals been made to other agencies / services? ***Please Specify if known***

REHABILITATION GOALS

Presenting Difficulties (Requirements for Treatment)

- ☐ difficulty with arm and hand function
- ☐ difficulty with walking and getting around
- ☐ improve balance/decrease falls
- ☐ difficulty with vision and perception
- ☐ talking
- ☐ understanding
- ☐ difficulty swallowing
- ☐ managing emotional changes
- ☐ adjusting to live after stroke
- ☐ difficulty returning to daily activities
- ☐ taking care of self
- ☐ eating well and preparing meals
- ☐ fatigue
- ☐ return to life roles
- ☐ difficulty with memory and/or thinking
- ☐ concerned about finances
- ☐ impulsiveness
- ☐ other:

Additional Information:

PLEASE FAX COMPLETED FORM TO 519-685-4802