GTA REHAB NETWORK

OUTPATIENT/AMBULATORY REHAB REFERRAL FORM*

The Outpatient/Ambulatory Rehab Referral Form is to be used for referrals to multiple rehab services provided by the GTA Rehab Network member organizations. This referral form is not intended to be used for referrals to medical/diagnostic services.

Note: The rehab programs/services offered by organizations may vary. For detailed information about programs offered by specific organizations, please refer to Rehab Finder at www.gtarehabnetwork.ca/RehabFinder.asp or contact the organization directly.

The development of this new form has been supported by funding from the Toronto Central LHIN.

Please note: Referrers who use the E-Stroke Rehab Referral system for stroke rehab referrals should continue to use the electronic referral system.

Referrers, when making an outpatient rehab referral, consider ….

- ✓ If the client is able to access transportation to/from the program
- ✓ The inclusion / exclusion criteria of the rehab service to which you are applying. For example, wandering might be an exclusion criterion unless the client is accompanied by a caregiver.
  (Descriptions of rehab services / programs offered by GTA Rehab Network members can be found on ***Rehab Finder*** at www.gtarehabnetwork.ca/RehabFinder.asp)

Rehab referral receivers, when reviewing the Outpatient/Ambulatory Rehab Referral…

- ✓ If the client does not meet the eligibility criteria of your program, provide information on rehab services / program options offered by other programs/organizations or community services

For each referral…

- ✓ Complete each section of the referral form
- ✓ Fax the referral directly to the program/service you are requesting as per the organization's intake process (Information on the application process is available on ***Rehab Finder*** at www.gtarehabnetwork.ca/RehabFinder.asp)

*Copies of the Outpatient / Ambulatory Rehab Referral Form can be downloaded from the GTA Rehab Network's website at www.gtarehabnetwork.ca/referral_forms.asp.

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SECTION 1: DEMOGRAPHIC INFORMATION

*PATIENT'S NAME:*____
(LAST NAME, FIRST NAME)

GENDER ☐ M ☐ F

DOB ___________________ (yyyy/mm/dd)

HOME ADDRESS Apt # Postal Code

Home Telephone Number : Alternate Phone Number:

HEALTH CARD NUMBER **Version** **Expiry Date (If available)**

Province/Territory issuing Health Card: ☐ Ontario Country/Province # ☐ Other (Specify): ______________________________

RESPONSIBILITY FOR PAYMENT (IF NOT OHIP)

☐ Private Insurer ☐ WSIB___________________ ☐ Auto Insurance ☐ Veteran ☐ Self Pay

☐ IFH (Interim Federal Health Grant)__________________________ ☐ Out of Province ______________________________________

SPEAKS, UNDERSTANDS ENGLISH ☐ Yes ☐ Minimal ☐ No

If Minimal/No, is family interpreter available? ☐ Yes ☐ No If no, interpreter is needed for what language? ______________________________

SUBSTITUTE DECISION MAKER (SDM) / POWER OF ATTORNEY (POA) / EMERGENCY CONTACT INFORMATION

Name: Daytime Tel. No. Relationship to Client:

PRIMARY CONTACT TO ARRANGE APPOINTMENTS : ☐ Client ☐ SDM/POA ☐ Emergency Contact

Provide name and daytime telephone if different from client or individual listed above ____

FAMILY PHYSICIAN'S CONTACT INFORMATION **:** ☐ No Family Physician

Name: Phone: Fax:
Address: Billing No. (if available):

SECTION 2: REFERRAL INFORMATION

*REFERRAL DATE:*____(YYYY/MM/DD)

REFERRAL CONTACT: Contact name/position: ____ Phone: ( ) ____________________
Organization & Program/Service: ____ Pager: ( ) _____________________

CLIENT IS CURRENTLY: ☐ at home ☐ other (specify)

IF CLIENT IS IN HOSPITAL: Date of Admission: _____ / _____ / _____ (YYYY/MM/DD) Planned Date of Discharge: ______ / ______ / ______ YYYY/MM/DD)

PRIMARY DIAGNOSIS:

REHAB POPULATION: ☐ ABI ☐ Amputee ☐ Burns ☐ Cardiac ☐ General/Medical ☐ Geriatric ☐ MSK ☐ Neuro

☐ Oncology ☐ Pulmonary ☐ Spinal Cord ☐ Trauma ☐ Transplant ☐ Other_______________________________

REHAB SERVICE(S) REQUESTED: Note: Not all organizations provide all services listed below. For detailed information about programs offered by specific organizations, please refer to Rehab Finder at www.gtarehabnetwork.ca/RehabFinder.asp or contact the organization directly.

☐ Occupational Therapy ☐ Physiotherapy ☐ Dietician ☐ Social Work ☐ Nursing ☐ Physiatry ☐ Psychology

☐ Therapeutic Recreation ☐ Speech Language Pathology / Swallowing ☐ Speech Language Pathology/ Communication ☐ Psychiatry

☐ Other rehab services required (e.g. Seating Clinic, Vocational Rehab, Pain Management Clinic, Augmentative Communication/Writing Clinic etc.)
Specify:

SPECIAL CONSIDERATIONS: (E.G. HOUSING, TRANSPORTATION, SOCIAL SUPPORT, VISUAL IMPAIRMENT, OTHER IDENTIFIED RISKS)

(If available, attach Social Work report)

IS CLIENT CURRENTLY RECEIVING OTHER REHAB SERVICES? ☐ No ☐ Yes (specify)

REPORTS ATTACHED? (e.g. CT scan, OT/PT/SLP/SW notes etc.) ☐ Yes ☐ No

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SECTION 3: REASON FOR REFERRAL | *PATIENT'S NAME:*______________________________
(LAST NAME, FIRST NAME)

To be completed by Physician *or* Physician Designate *or* allied health professional (e.g. PT, OT, SLP, SW, RN)

PATIENT GOALS/TREATMENT PLAN (Identify SMART goals – specific, measurable, attainable, realistic and timely)

BASIC PERSONAL ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Self-care ☐ Toileting ☐ Pain ☐ Medication Management ☐ Other: ______________________________

Goals/Comments:

MOBILITY ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

Ambulation: ☐ Independent ☐ Assistance ☐ Supervision Mobility Aid: ______________________________

Transfers: ☐ Independent ☐ Assistance ☐ Supervision If aid required:______________________________

Activity Tolerance (specify): ______________________________

☐ Paresis/paralysis ☐ Falls/history of falls ☐ Other: ______________________________

Goals/Comments:

BEHAVIOUR ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Wandering ☐ Aggressiveness ☐ Other:______________________________

Goals/Comments:

SWALLOWING ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Intact, regular diet ☐ Dental soft diet ☐ Minced diet ☐ Pureed diet ☐ Thickened fluids

Goals/Comments:

COMMUNICATION ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Hearing ☐ Vision ☐ Language, comprehension ☐ Language, expression ☐ Speech Dysarthria ☐ Speech Apraxia

☐ Other (specify)

Goals/Comments:

COGNITIVE ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Orientation ☐ Participation ☐ Judgment ☐ Carryover/New Learning ☐ Memory ☐ Frustration tolerance ☐ Other ______________

Goals/Comments:

COMPLETED BY:	*PHONE:*	*DATE:*

OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

SECTION 4: RELEVANT MEDICAL INFORMATION

To be completed by Physician or Physician Designate

*PATIENT'S NAME:*______________________________
(LAST NAME, FIRST NAME)

ALLERGIES: ☐ No ☐ Yes (list):

PRIMARY DIAGNOSIS & HISTORY OF PRESENTING ILLNESS (relevant to reason for referral): **Date of Injury/Onset:** ____________ yyyy/mm/dd

PAST MEDICAL / SURGICAL HISTORY (relevant to rehab referral): **Date of Surgery :** ____________ yyyy/mm/dd

For ABI/Neuro Referrals Only (where applicable):

Trauma ☐ No ☐ Yes Seizures: ☐ No ☐ Yes Loss of Consciousness: ☐ No ☐ Yes

Post-Traumatic Amnesia Resolved? ☐ No ☐ Yes Previous history of ABI? ☐ No ☐ Yes ____________

CT/MRI Date of Completion: ______ / ______ / ______ Facility: ____________ (attach report)

RELEVANT MENTAL HEALTH HISTORY: ☐ No ☐ Yes If yes, describe history, current status including suicide risk, provide recent consult notes and details of follow-up arrangements:

Followed by ACT Team/Case Manager? ☐ No ☐ Yes (Specify contact information):

SUBSTANCE ABUSE: History of Substance Abuse: ☐ No ☐ Yes ☐ History not available

Current Substance Abuse: ☐ No ☐ Yes ☐ Not known Substance Abuse Treatment Recommended: ☐ No ☐ Yes

INFECTIOUS DISEASE: ☐ No ☐ Yes (specify below) ☐ Unknown

Does individual currently have:

MRSA: ☐ No ☐ Yes Location: ____________ VRE: ☐ No ☐ Yes Location: ____________

C-Difficile: ☐ No ☐ Yes Other(specify):

WEIGHT BEARING STATUS AS ORDERED BY MD: ☐ No restrictions

Left: ☐ Right: ☐ ☐ As tolerated ☐ Partial_________% ☐ Touch weight bearing ☐ Non weight bearing

Precautions and restrictions: ____________ Date to become weight bearing: ____________

CARDIOVASCULAR & PULMONARY HISTORY: (As applicable) ☐ None known

Pacemaker/ICD ☐ No ☐ Yes

If yes, name of pacer clinic: ____________

Previous CVA	☐ No	☐ Yes	Pulmonary Disease	☐ No	☐ Yes
Peripheral Vascular Disease	☐ No	☐ Yes	Myocardial Infarction	☐ No	☐ Yes
Heart Failure	☐ No	☐ Yes	Atrial Fibrillation/Other arrhythmias	☐ No	☐ Yes

Known Cardiac Risk Factors:

☐ Hypertension ☐ Diabetes I / II

☐ Family History ☐ Hyperlipidemia

☐ Smoking

SAFE TO PARTICIPATE IN WARM THERAPEUTIC POOL (HYDROTHERAPY) IF THERAPIST INDICATES THIS IS NECESSARY? ☐ No ☐ Yes

HAS THE MINISTRY OF TRANSPORTATION BEEN NOTIFIED OF PATIENT'S MEDICAL STATUS? ☐ No ☐ Yes

REFERRING PHYSICIAN: I authorize a referral for this individual for the services specified.

Name: ____________ Phone: ( ) ____________

Signature: ____________ Date: ____________ (yyyy/mm/dd)

Billing No. (if available): ____________ Hospital: ____________

OUTPUTPATIENT/AMBULATORY REHAB REFERRAL FORM

SECTION 5: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager)

☐ I agree that ____ may release my personal health information to make a referral.
(Referral source disclosing information)

Organization(s) referred to:

___ Baycrest
___ Bridgepoint Health
___ Credit Valley Hospital
___ Halton Healthcare Services
___ Lakeridge Health
___ Markham Stouffville Hospital
___ North York General Hospital
___ Rouge Valley Health System
___ Southlake Regional Health Centre
___ St. John's Rehab Hospital
___ St. Joseph's Health Centre
___ Sunnybrook Health Sciences Centre
___ The Scarborough Hospital
___ Toronto Rehab
___ Trillium Health Centre
___ University Health Network
___ West Park Healthcare Centre
___ York Central Hospital
Other (specify): __________
____

For Acquired Brain Injury (ABI) referrals only:

The Toronto ABI Network may use summaries of your referral information to find trends that show how patients use health services. This may help answer research questions about the type of rehab patients apply for and the course of treatment. Your information would be collected from the system then combined with the information of other patients. Your name and personal health information would not be used in any public reporting. A Research Ethics board must approve all research projects before your information can be used. If you do not want your personal health information to be used, this decision will not affect your medical care in any way.

☐ Yes, my health information may be used for system improvement and research. My name and personal health information would not be used in any public reporting.

☐ No, my health information may not be used for system improvement and research.

To be completed for all referrals:

Print Name of Patient: ____

Signature of Patient/Substitute: ____

If unable to obtain signature, has verbal consent been obtained? ☐ Yes

Witness: ________________________________
(Print name)

____
(Signature)

Name of Substitute: (Print name) ____

Relationship to patient, if signed by Substitute: ____

☐ Yes, an interpreter was used when consent was obtained.
☐ No interpreter was required.

Date:(YYYY/MM/DD)_________________