GRAND RIVER HOSPITAL

REFERRAL TO OUTPATIENT REHAB SERVICES: Freeport Health Centre

The NeuroRehabilitation Clinic / Day Hospital

Referral should be made to the **Day Hospital** when a client meets the following criteria:

- Requires a comprehensive interdisciplinary approach to rehabilitation (2 days per week) in a group setting, to attain maximum functional independence. Client requires two or more disciplines (OT, Physio, Nursing, Social Work, Dietician, Recreation Therapy, Speech Pathology).
- Able to manage in the community with appropriate community resources.
- Able to tolerate travel to and from the program in addition to therapy.
- Medical and rehabilitation needs can be met within the clinic.
- Is an older individual (generally over 65 years of age).
- Physician referral for treatment needed.

All referral applications must include a complete past & present Medical history and Medication profile

Referral should be made to the **NeuroRehabilitation Clinic** when a client meets the following criteria:

- Requires individual, intensive, and selective occupational therapy, physiotherapy, social work, or speech/language therapy to attain functional goals.
- Able to manage in the community with appropriate support resources.
- Medically stable.
- Able to tolerate travel to and from the clinic in addition to therapy.
- Medical and rehabilitation needs can be met within the clinic.
- Demonstrates sufficient cognitive skills to participate in goal setting and to be able to integrate new learning skills into daily life.
- Minimum of 16 years of age.
- Physician referral for treatment needed.

Send completed form to: Day Hospital/The NeuroRehabilitation Clinic, Grand River Hospital, Freeport Health Centre P.O. Box 9056, Kitchener, Ontario N2G 1G3 (519) 894-8340 FAX (519) 894-8307

PATIENT IDENTIFICATION

Last name	First name	Initial	Birth Date year / month / day	
Address	City	Province	Postal code	
Home phone number	Business phone number	Health card #		Sex ❒ Male ❒ Female

NEXT-OF-KIN / CAREGIVER IDENTIFICATION

___ ***Patient has consented to using these numbers for contact and leaving messages.**

Last name	First name	Relationship
Home phone number	Business phone number	

DRIVING HISTORY: Valid License? ____ Date of Last Driver's Test ___________________

CURRENT MEDICAL HISTORY (Date of onset ___________________) Include relevant consults, special testing results	**MEDICATIION PROFILE (may attach a list)**
Does this person have a *current* ARO infection? ☐No ☐ Yes ☐MRSA ☐VRE ☐C.Diff ☐ESBL	

RELEVANT PAST MEDICAL HISTORY

Is there a *history* of AROs (antibiotic resistant organisms)? ☐No ☐ Yes ☐MRSA ☐VRE ☐ ESBL

REFERRAL TO OUTPATIENT REHAB SERVICES: Freeport Health Centre

The NeuroRehabilitation Clinic / Day Hospital

PROGRAM REQUESTED

❐ NeuroRehabilitation Clinic ❐ Day Hospital

SERVICES REQUIRED (referral to the clinic could result in any or all of the listed services being utilized)

❐ Dietitian ❐ Nursing ❐ O.T.
❐ Speech Pathology ❐ Recreation Therapy ❐ P.T. ❐ Social Work

***If our team feels that the patient could benefit from a consultation by a Geriatrician or Geriatric Psychiatrist:**

❐ **The team may make the referral on the physician's behalf and send a copy to their office.**
❐ **Do not make referral, please contact physician first.**

REASON FOR REFERRAL

Problem	**Current Status**
_______	
_______	
_______	

__ referral form was completed with client (or substitute decision maker), and reason for referral has been discussed.

ALLERGIES (describe allergic reaction)

❐ None known ❐ Drug allergies _________________________ ❐Food allergies______________________________

DIET | If other than Regular __________________

CURRENT COMMUNITY SERVICES INVOLVED

❐ Home Care ______________________ ❐ Other _______________________________ -

Case Manager _______________________ Phone No. __________________Cell No. ______________________

TRANSPORTATION TO FREEPORT:

❐ Private ❐ Wheelchair Taxi ❐ Mobility Plus __ Other____________________

FAMILY PHYSICIAN IDENTIFICATION

Last name	First name	Office No.	
Address	City	Province	Postal code

PHYSICIAN SIGNATURE (Required)

	Date year / month / day

REFERRAL SOURCE

Last name	First name	Office phone number
Discipline	Name of service	Date year / month / day