NEURO REHAB PHYSIATRY CLINIC
Physical Medicine and Rehabilitation
Outpatient Referral Form

WRHN @ Chicopee, Pioneer Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-749-4300, ext. 7860 Fax: 519-894-8310

PHYSIATRY REFERRAL REQUIREMENTS:

For the referral to be considered, the following referral criteria must be met:

- ✓ There is a confirmed neurological diagnosis (for example, stroke, spinal cord injury, brain injury, neuromuscular condition).
- ✓ The condition is acute, or chronic with a deteriorated function requiring optimization.
- ✓ Relevant information must be included to allow for appropriate assessment:
- ✓ Summary of diagnostics
- ✓ Summary of past and present rehabilitation, if known
- ✓ Medical information including current medications

Additionally the client must meet all of the following criteria for the programs:

- ✓ Medically stable.
- ✓ Able to tolerate travel to and from the clinic. In some cases, virtual follow-up appointments may be offered.
- ✓ Physician referral is required for Physiatrist review.

Patient Identification

Last Name:	First Name:	Middle Initial:	Birth Date: (year/month/day)
Address:	City:	Province:	Postal Code:
Birth Sex: ❒Male ❒Female ❒Other_____		Gender: ❒Male ❒Female ❒Other_____	
Home Phone #:	Cell Phone #:	Health card #: Expiry:	Version Code:

Alternate Contact ❒Emergency Contact ❒Substitute Decision Maker (SDM) ❒Power of

Last Name:	First Name:	Relationship:
Home Phone #:	Business Phone #:	Cell Phone

To arrange appointments contact: ❒Patient ❒Alternate Contact ❒Other:_____

❒The patient/SDM has consented to messages being left at the above phone numbers.

Referral Request

REFERRING DIAGNOSIS:	
DATE OF ONSET:	
RELEVANT PAST MEDICAL HISTORY:	
GOALS / REQUESTS of referral (Current Status, Expected outcomes, etc.):	

***Please Note:** Relevant information that cannot be accessed on Cerner must be attached as above*

Does this person have *any current* ARO infection / isolation concerns? ❒Yes ❒No
(Please Specify): ❒MRSA ❒VRE ❒C.Diff ❒ESBL ❒Other: _____

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WRHN
Waterloo Regional Health Network

CURRENT THERAPY

Medication Profile (Please list or attach the current medication list with dosages)

Allergies (describe allergic reaction)

❒ None known ❒ Drug allergies_____ ❒Food or Environmental allergies_____

Allergic reaction:

Current Diet (including texture modifications):

Transportation (How will the patient get to the WRHN @ Chicopee Rehabilitation?)

□Family/Friend will drive □Mobility Plus/Kiwanis Transit □Bus or Taxi □Patient will drive self

Special Considerations / Comments (e.g. language barriers, requires special assistance)

☐ ☐ The referral form was completed with the client/substitute decision maker, and the reason for the referral has been discussed.

Referral Source

Last Name:	First Name:	Office phone #:
Discipline:	Name of service:	Date: (year/month/day)

Family Physician

Last Name:	First Name:	Phone #:
		Fax #:

Referring Physician

Last Name:	First Name:	Phone #:
		Fax #:

Physician Signature (REQUIRED)

	Billing #:	Date: (year/month/day)

Fax Completed Form (2 pages) to Fax #: 519 894 8310
Please direct any questions via phone to #: **519 749 4300 ext. 7860**

NOTE: Please attach medication profile and all relevant reports.
All incomplete referral forms will be returned to referral source for completion