WRHN
Waterloo Regional Health Network

# NEURO REHABILITATION CLINIC
## Outpatient Referral Form

**WRHN @ Chicopee, Union Terrace 1st Floor**
**3570 King Street East, Kitchener, Ontario, N2A 2W1**
**Phone: 519-894-8340 Fax: 519-894-8307**

**NEUROREHABILITATION CLINIC REFERRAL REQUIREMENTS:**

For the referral to be considered, one of the following referral criteria must be met. Has the individual experienced:

- ❑ Acute neurological (CNS) diagnosis, or
- ❑ Acute change in status of the neurological diagnosis, or
- ❑ Neurological diagnosis impacting recovery from an acute medical change.

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

- ✓ Must have specific attainable goals that can be met within the outpatient clinic.
- ✓ Demonstrates sufficient cognitive skills to participate in goal setting and to be able to integrate new learning into daily life.
- ✓ Minimum of **18** years of age.
- ✓ Medically stable.
- ✓ Able to tolerate travel to and from the clinic in addition to therapy
- ✓ Physician referral is required for assessment and treatment.

**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 Attorney

| | | |
|---|---|---|
| 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.**

**Services Requested**

❒ Occupational Therapy ❒ Physiotherapy ❒ Recreation Therapy ❒ Social Work ❒ Speech Language Pathology ❒ Dietitian

| | |
|---|---|
| **REFERRING DIAGNOSIS:** | |
| **DATE OF ONSET:** | |
| **RELEVANT PAST MEDICAL HISTORY:** | |
| **REHABILITATION GOALS (Current Status, Expected outcomes, etc.)** | |

*** EXPECTED DISCHARGE DATE (if still in hospital):**

***Please Note:** Recent discharge summaries and any relevant medical reports must be attached*

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



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**Driving Information *Please discuss any medical/functional concerns with the patient before submitting this referral***

Is the patient medically fit to drive? ❒Yes ❒No ❒Uncertain

Has the Ministry of Transportation been informed that the patient has a medical condition that may affect their ability to drive?

❒Yes ❒No ❒Uncertain

**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, Neuro Rehabilitation Clinic?)

❒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 etc.)**

❒

❒ ❒ 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 #: 519-894-8307**
Please direct any questions via phone to #: **519-894-8340**

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



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