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 https://gtarehabfinder.ca/ or contact the organization directly.

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

Please note:

- Acute care referrers in Toronto who use the E-Stroke Rehab Referral system for stroke rehab referrals should continue to use the electronic referral system for outpatient referrals.
- Use this form for all rehab populations **except** total joint replacements and acquired brain injury.
- Referrals for outpatient rehab following total joint replacements should use the TJR Outpatient Rehab Referral Form
- Referrals for patients with an Acquired Brain Injury should use the Toronto ABI Network's ABI Community Profile, which can be downloaded at http://www.abinetwork.ca/community-form.

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 https://gtarehabfinder.ca/)

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 https://gtarehabfinder.ca/)

*Copies of the Outpatient / Ambulatory Rehab Referral Form can be downloaded from the GTA Rehab Network's website at http://www.gtarehabnetwork.ca/outpatient-ambulatory.

July 2015 / Rev June 2019

GTA REHAB Network

OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

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: ☐ 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 https://gtarehabfinder.ca/ or contact the organization directly.

☐ Dietitian	☐ Kinesiology	☐ Nursing	☐ Occupational Therapy	☐ Physiatry	☐ Physiotherapy
☐ Psychiatry	☐ Psychology	☐ Speech Language Pathology/ Communication		☐ Speech Language Pathology / Swallowing	
☐ Social Work	☐ Therapeutic Rec.	☐ 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 etc.)

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:***

GTA REHAB Network

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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

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: _____

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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 Active Healthcare/Sinai Health System
__ Halton Healthcare Services
__ Lakeridge Health
__ Markham Stouffville Hospital
__ Mackenzie Health
__ North York General Hospital
__ Providence Healthcare/Unity Health Toronto
__ St. John's Rehab Hospital /Sunnybrook Health Sciences Centre
__ Scarborough Health Network
__ Southlake Regional Health Centre
__ Sunnybrook Health Sciences Centre
__ St. Joseph's Health Centre /Unity Health Toronto
__ St. Michael's /Unity Health Toronto
__ Toronto Rehab/University Health Network
__ Trillium Health Partners
__ University Health Network
__ West Park Healthcare Centre

Other (specify): _____

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)_____