HÔTEL-DIEU GRACE HEALTHCARE

Specialized Neurologic and Complex Rehab Outpatient Clinic Referral Form

- ☐ **Rehab Outreach (Ext. 75116)**
- ☐ **Outpatient Rehab (Ext. 75200)**
- ☐ **Acquired Brain Injury (Ext. 75458)**
- ☐ **Persistent Post – Concussion Clinic (must be at least 4 weeks post event)**

CLIENT INFORMATION	
Name:	DOB (MM/DD/YY):
Address:	Phone #:
City/Town:	Postal Code:
Health Card Number:	Version Code:
Does the client have a Substitute Decision Maker: ☐ Yes ☐ No If YES, please provide name:	Phone #: Relationship to Client:
Does client consent to referral? ☐ Yes ☐ No ****Consent is required for referral to be processed****	
Employment Status: ☐ Unemployed ☐ Retired ☐ Working	
Preferred Language: ☐ English ☐ French ☐ Other (please indicate):	

DRIVING INFORMATION
Has the Ministry of Transportation been informed the client has a medical condition that may affect their ability to drive? ☐ Yes ☐ No
Will transportation be an issue? ☐ Yes ☐ No ☐ Family ☐ Transportation Service

PHYSICIAN INFORMATION	
Primary Care Practitioner:	Tel #:
Referring Practitioner: Signature: _____	Tel #:
Referral Source: ☐ Primary Care Practitioner ☐ Specialist	
Name of person filling out this form:	Tel #:

REFERRAL CRITERIA	
Referring Diagnosis:	Date of Onset:
Disciplines Referred: ☐ PT ☐ OT ☐ SLP ☐ Clinical Dysphagia Assessment ☐ SW ☐ Neuropsychology	
Is this referral a result of a work related injury: ☐ Yes ☐ No	
Is this referral a result of a motor vehicle accident: ☐ Yes ☐ No	

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REASONS FOR REFERRAL

☐ difficulty with arm and hand function	☐ swallowing concerns
☐ improve balance/decrease falls	☐ difficulty with memory and/or thinking
☐ difficulty with vision and perception	☐ prosthetic training post amputation
☐ difficulty with walking	☐ impulsiveness
☐ speech concerns	☐ difficulty returning to normal activities
☐ managing emotional changes	☐ other

PATIENT HISTORY

Relevant Medical History (includes history of seizures, dementia, previous history of ABI etc):

Does the client (and/or family member) have a history of Responsive Behaviours:
☐ Yes ☐ No
If YES, please describe:

Does the client have a history of Substance Use, Criminal Offences/Charges, Psychiatric Diagnoses:
☐ Yes ☐ No
If YES, please describe:

Infection Control: ☐ MRSA ☐ VRE ☐ CDIFF ☐ Cytotoxic Meds ☐ Other

Allergies (including Latex and Environmental Reaction):
☐ Yes ☐ No
If YES, please specify allergy and reaction:

Is the client currently involved with Home Care services?
☐ Yes ☐ No
If YES, please specify:

Is the client currently involved with other community agencies or services?
☐ Yes ☐ No
If YES, please specify:

Please include a recent consult note along with any relevant reports/discharge summaries and fax completed referral to:
(519) 257-5299