



Health Record #: _____ Complete or place barcoded patient label here
 Patient Name: *(Print first, last)* _____
 DOB: dd / mm / yy Age: _____ Female Male
 OHIP #: _____ Version Code: _____
 Account #: _____ Date of Admission: dd / mm / yy

Rehabilitation Referral

NOTE: If this referral is not complete or is illegible, it will be returned and the commencement of your patient's treatment may be delayed.

<input type="checkbox"/> ARTHRITIS PROGRAM Fax: 905-952-2816	
<input type="checkbox"/> OCCUPATIONAL THERAPY Fax: 905-830-5982	<input type="checkbox"/> Hand Program
<input type="checkbox"/> PHYSIOTHERAPY Fax: 905-830-5982	<input type="checkbox"/> Paediatrics (0-6 yrs) <input type="checkbox"/> Paediatrics Orthotic Clinic
<input type="checkbox"/> Orthopaedics: <input type="checkbox"/> Prehab <input type="checkbox"/> Post Surgery <input type="checkbox"/> General	
Patient Name: <i>(print first, last)</i> _____	
Date of Birth: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Patient Address: <input type="checkbox"/> SRHC Inpatient <input type="checkbox"/> Other: _____	
Telephone # Home: _____	Alternate Phone #: _____
Health Card #: _____	Version Code: _____
WSIB: _____	
Emergency Contact or Parent/Guardian Name: <i>(if under 16 yrs)</i> _____	
Telephone # Home: _____	Alternate Phone #: _____
DIAGNOSIS:	
Date of Onset: <u>dd</u> / <u>mm</u> / <u>yy</u>	Date of Surgery: <u>dd</u> / <u>mm</u> / <u>yy</u>
X-ray information/Lab Work:	
Required Information for Spinal Conditions:	
Radicular Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes	TO <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Knee <input type="checkbox"/> Foot
Neurological Signs: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Relevant Informations/Other Conditions:	
<input type="checkbox"/> Age 65 or over	
<input type="checkbox"/> Age 19 or younger	
<input type="checkbox"/> ODSP/Ontario works	
Off work due to this episode: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date of last time worked: <u>dd</u> / <u>mm</u> / <u>yy</u>	
Precautions: <input type="checkbox"/> Malignancy <input type="checkbox"/> Diabetes <input type="checkbox"/> Cardiac <input type="checkbox"/> Respiratory <input type="checkbox"/> Other <i>(explain)</i> _____	
Weight Bearing Status: <input type="checkbox"/> Non WB <input type="checkbox"/> Partial WB <input type="checkbox"/> Full WB <input type="checkbox"/> Wheelchair	
BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL	
Referring Physician Name: <i>(print first, last)</i> _____	Billing #: _____
Referring Physician Signature: _____	Date: <u>dd</u> / <u>mm</u> / <u>yy</u>
Phone Number: _____	Fax Number: _____
Other Physicians to receive copies of report:	
CLINIC USE ONLY	
Date referral received: <u>dd</u> / <u>mm</u> / <u>yy</u>	APPOINTMENT – Date: <u>dd</u> / <u>mm</u> / <u>yy</u> Time: _____

