

Health Record #: _____	Complete or place barcoded patient label here
Patient Name: <i>(Print first, last)</i> _____	
DOB: <u>dd</u> / <u>mm</u> / <u>yy</u>	Age: _____ <input type="checkbox"/> Female <input type="checkbox"/> Male
OHIP #: _____	Version Code: _____
Account #: _____	Date of Admission: <u>dd</u> / <u>mm</u> / <u>yy</u>

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"/> OCCUPATIONAL THERAPY Fax: 905-830-5982		<input type="checkbox"/> Hand Program	
<input type="checkbox"/> PHYSIOTHERAPY Fax: 905-830-5982		<input type="checkbox"/> Paediatrics (0-2 yrs)	
<input type="checkbox"/> Orthopaedics: <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"/> SH 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: _____	

