SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

The John + Margaret Bahen Rehabilitation Program

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.

❑ **OCCUPATIONAL THERAPY** Fax: 905-830-5982 ❑ Hand Program
❑ **PHYSIOTHERAPY** Fax: 905-830-5982 ❑ Paediatrics (0-2 yrs)
❑ Orthopaedics: ❑ Post Surgery ❑ General

Patient Name: *(print first, last)* **Date of Birth:** dd / mm / yy

Patient Address: ❑ SRHC Inpatient ❑ Other: _____

Telephone # Home: **Alternate Phone #:**

Health Card #: **Version Code:** **WSIB:**

Emergency Contact or Parent/Guardian Name: *(if under 16 yrs)*

Telephone # Home: **Alternate Phone #:**

DIAGNOSIS:

Date of Onset: dd / mm / yy **Date of Surgery:** dd / mm / yy

X-ray information/Lab Work:

Required Information for Spinal Conditions:

Radicular Pain: ❑ No ❑ Yes TO ❑ Elbow ❑ Wrist ❑ Knee ❑ Foot

Neurological Signs: ❑ No ❑ Yes

Relevant Informations/Other Conditions:

❑ Age 65 or over
❑ Age 19 or younger
❑ ODSP/Ontario works

Off work due to this episode: ❑ No ❑ Yes If yes, date of last time worked: dd / mm / yy

Precautions: ❑ Malignancy ❑ Diabetes ❑ Cardiac ❑ Respiratory ❑ Other *(explain)* _____

Weight Bearing Status: ❑ Non WB ❑ Partial WB ❑ Full WB ❑ Wheelchair

BY SIGNING THIS FORM, I CONFIRM THAT THIS PATIENT IS AWARE OF THIS REFERRAL

Referring Physician Name: *(print first, last)* **Billing #:**

Referring Physician Signature: **Date:** dd / mm / yy

Phone Number: **Fax Number:**

Other Physicians to receive copies of report:

CLINIC USE ONLY

Date referral received: dd / mm / yy **APPOINTMENT – Date:** dd / mm / yy **Time:** _____

S-REHRR