



596 Davis Drive  
Newmarket, ON L3Y 2P9

Rehabilitation Department - 905-895-4521, Ext. 2422

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> _____

## Out-Patient Neurological Rehabilitation Referral

**Please fax to: 905-830-5982**

<b>Patient Name:</b> <i>(print first, last)</i> _____		<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Address:</b> <i>Street Number and Name</i> _____		<i>Apartment</i> _____	
<i>City</i> _____		<i>Province</i> _____	
<i>Postal Code</i> _____			
<b>Phone Number:</b> _____		<b>Marital Status:</b> _____	
<b>Health Card #:</b> _____		<b>Version Code:</b> _____	
<b>Date of Birth:</b> <u>dd</u> / <u>mm</u> / <u>yy</u> _____			
<b>Contact Person:</b> <i>(print first, last)</i> _____		<input type="checkbox"/> Will arrange appointments	
<b>Relationship to Patient:</b> _____		<b>Phone Number:</b> _____	
<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other: _____		<input type="checkbox"/> Translation available/requested	
<b>Primary Diagnosis:</b> _____ _____			
<b>Rehab Services Requested:</b> <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> SLP			
<b>Reports Attached:</b> <input type="checkbox"/> CT Scan <input type="checkbox"/> MRI <input type="checkbox"/> Neurologist <input type="checkbox"/> OT/PT/SLP <input type="checkbox"/> Recent Physician Summary			
<b>Special Considerations:</b> _____ _____			
<b>REASON FOR REFERRAL:</b> <i>(Please check all that apply and provide additional relevant details in the space provided.)</i>			
<input type="checkbox"/> ADL <input type="checkbox"/> Mobility <input type="checkbox"/> Behaviour <input type="checkbox"/> Swallowing <input type="checkbox"/> Communication <input type="checkbox"/> Cognition <input type="checkbox"/> Return to Work/School <input type="checkbox"/> Home Safety		<b>Issues/Goals:</b> _____ _____	
<b>Family Doctor:</b> <i>(print first, last)</i> _____		<b>Phone Number:</b> (    ) _____	
<b>Referral Source:</b> _____		<b>Phone Number:</b> (    ) _____	
<b>Referral Source Contact:</b> <i>(print first, last)</i> _____		<b>Designation:</b> _____	
<b>Signature:</b> _____		<b>Date:</b> <u>dd</u> / <u>mm</u> / <u>yy</u> _____	

**PLEASE FAX REFERRAL WITH RELATED CONSULTATION NOTES, CURRENT MEDICATION LIST AND/OR RECENT LAB RESULTS.**

**See reverse for Admission and Exclusion Criteria.**

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## ***Out-Patient Neurological Rehabilitation Referral***

### **ADMISSION AND EXCLUSION CRITERIA**

#### **Admission Criteria:**

- Alpha-FIM and/or FIM completed
- Acute event (less than 6 months post injury): CVA (ischemic or hemorrhagic), neuro trauma, anoxic brain injury, infectious neurological injury, spinal cord injury
- 2 or more services required (PT, OT, SLP)
- Able to participate in active rehab program (2-3 hours per day, 5-7 days per week)
- Goals can be achieved within the framework of out-patient rehab (maximum length of stay: 8 weeks)
- Established transportation
- Social support for completion of home programming (if cannot be performed independently)
- Adherence to cancellation policy (excluding inclement weather)
- Home address within Central Local Health Integration Network (LHIN)
- Will consider prior rehabilitation services received (i.e., in-patient, out-patient, private)

#### **Exclusion Criteria:**

- In-patient rehab discharge FIM score less than 40
- Chronic event (greater than 6 months post injury)
- Single service required
- Insufficient activity tolerance for participation in active out-patient rehab program
- Goals not achievable within the framework of out-patient rehab
- No transportation
- No social support for completion of home programming (if cannot be performed independently)
- Progressive neurological disease as primary diagnosis
- Home address outside of Central LHIN
- Concurrent direct intervention provided by another OHIP-funded service (convalescence, HC&C rehab services)
- Concurrent direct intervention provided by private therapist