Outpatient Neuro Rehab Services
Referral Form

This form is for Trillium inpatients and the Stroke Prevention Clinic only.

Patient Information

Name ____________________________________________________    Gender __________________________________________
Referring Physician _________________________________________ Family Physician _____________________________
Date of admission to hospital: _____________ Expected Discharge date _____________ Expected Discharge Location ___________
Diagnoses ___________________________________________________________________________________________________
Other Health Issues: ___________________________________________________________________________________________
Allergies: ___________________________________ Code Status: ☐ Full resuscitation or ☐ ___________________________
Contact Person: _____________________________ Phone Number _____________________________________________
Primary Language Spoken __________________________________ Interpreter Available __________________________
Previous Functional Level (within past year, include work status) _______________________________________________________
☐Lives alone ☐ Lives with __________________________   Other supports _____________________________________
Social issues _____________________________________________________ CCAC Services requested ______________________

Home Access

Mobility aid used ____________________________________________________________
Stairs: Number of stairs to enter the home ________ Railings _______ Assistance required _____________
Will the client be able to exit and enter the home safely? _____________________________
Able to lock/unlock/open/close door? ___________ If not, assistance available ____________________

Services Recommended (Physician’s Orders)

- Referral to Outpatient Neuro Rehab Centre (OT, PT, SLP, SW, RN to assess and treat as needed)
To help us determine the initial needs, please identify the services recommended.

☐ OT    ☐ ADL/ IADL    ☐ Cognition    ☐ Perception    ☐ Driving    ☐ Upper extremity function    ☐ Return to work
Other: _________________________________________________________________________________________________
☐ PT    ☐ AFO    ☐ Assessment for mobility aid
☐ SLP    ☐ Communication    ☐ Swallowing
☐ SW
☐ RN    ☐ Education:    ☐ Diagnosis    ☐ Anticoagulation    ☐ Diabetes    ☐ Nutrition    ☐ Medications    ☐ Other _________
☐ Elimination    ☐ Pain Management    ☐ Other ________________

PHYSICIAN’S NAME: __________________________  Signature ________________________  Date: ________________________
Transportation (once to twice weekly)

- Self
- Family
- Trans Help
- Wheel Trans
- Other

Patient’s Driver’s License status ____________________________

Assistance While At the Neuro Rehab Centre / Functional Status

Eating:  ☐ Modified diet texture (including fluids)

- Setup
- Supervision for other reason ____________________________

Toileting:
- Continent of bladder:  ☐ Y  ☐ N
- Continent of bowel:  ☐ Y  ☐ N

- Setup
- Supervision for other reason ____________________________

Assistance required for toileting transfer:
- No
- 1 person min
- 1 person mod-max
- 2 person

Does this client have someone to assist them while attending the program?  ☐ Y  ☐ N

Transfers to chair:
- Independent
- Supervision
- 1 person min
- 1 person mod-max
- 2 person

Ambulation:
- Independent
- Supervision
- 1 person min
- 1 person mod-max
- 2 person

Cognition:
- Understands verbal instructions
- Understands written instructions
- Remembers verbal 2-step instructions
- Decreased insight/judgment

Risk of Falls:
- High
- Low

Additional Information: ____________________________

Behaviour:
- Impulsive
- Wanderer
- Aggressive
- Cooperative

Have referrals been made to other programs (Cardiac Rehab, Diabetes Management, other Neuro program)?

Inpatient Rehab Team Contacts

- OT
- PT
- RN
- SLP
- SW
- Other

Program criteria: The Outpatient Neuro Rehab Centre offers coordinated, comprehensive healthcare services for individuals diagnosed with a neurological condition.

Criteria:
- A RECENT neurological condition or significant change in status: stroke within the past 9 months, acquired brain injury (i.e. aneurysm) within 12 months, multiple sclerosis, degenerative conditions, etc
- Medically stable
- Clearly identified rehab goals
- Have demonstrated recent progress in recovery/rehabilitation
- Live within the defined catchment area
- Under the care of a family physician
- Activity tolerance sufficient for 1 hr of transportation and approx. 3 hr program (less for single service referral)
- Caregiver able to attend program with participant if participant requires more than 1 person’s assistance for toileting
- Not under the influence of alcohol or drugs while attending the program
- Behaviour must not pose a risk to self or others (e.g. aggressive behaviour)

FAX Referral, copies of all Discharge Summaries, Assessment Reports, Medication Reconciliation to 905-848-7537  Attention: Trillium Outpatient Neuro Rehab Centre  (Phone: 905-848-7580 x2474)