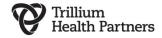


Outpatient Neuro Rehab Services Referral Form

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

| Patient Information | | | | |
|---------------------------------------|--|-----------------------------|---|--|
| Name | Gender | | | |
| | cian Family Physician | | | |
| | ion to hospital: Expected Discharge date | | | |
| | | | | |
| | | | | |
| | Code Status: □ Full resuscitation or □ | | | |
| | | | Phone Number | |
| | e Spoken | | > | |
| Previous Function | nal Level (within past year, include w | | | |
| | | | | |
| □Lives alone □ | Lives with | Other supports | | |
| Social issues CCAC Services requested | | | AC Services requested | |
| TT A | | | | |
| Home Acces | S | | | |
| 36199 | | | | |
| | | | | |
| | | | required | |
| | · · · · · · · · · · · · · · · · · · · | | | |
| Able to lock/unlock | ck/open/close door? I | f not, assistance available | | |
| G . B | | | | |
| Services Rec | commended (Physician's Ord | ers) | | |
| | | | | |
| Referra | al to Outpatient Neuro Rehab C | entre (OT, PT, SLP, SW | , RN to assess and treat as needed) | |
| To help us dete | ermine the initial needs, please | identify the services rec | ommended. | |
| \square OT | □ ADL/ IADL □ Cognition □ F | Perception Driving U | Upper extremity function □ Return to work | |
| | Other: | | | |
| □РТ | □ AFO □ Assessment for mobility aid | | | |
| \square SLP | □ Communication □ Swallowing | | | |
| \square SW | | | | |
| \square RN | □ Education: □ Diagnosis □Ant | icoagulation Diabetes | □ Nutrition □Medications □ Other | |
| | □ Elimination □ Pain Managemen | t 🗆 Other | | |
| | | | | |
| DHVCICIAN'S N | NAME. | Signature | Data | |



| Transporta | tion (once to twice weekly) | | | |
|---|---|--|--|--|
| - | y □ Trans Help □ Wheel Trans □ Other s License status | | | |
| Assistance ` | While At the Neuro Rehab Centre / Functional Status | | | |
| Eating: □ Modi | ified diet texture (including fluids) | | | |
| Assista | nce required for meals: Setup Supervision for other reason | | | |
| Toileting: | Continent of bladder $\ \square\ Y\ \square\ N$ Continent of bowel $\ \square\ Y\ \square\ N$ | | | |
| | Assistance required for toileting transfer: \square No $\square 1$ person min \square 1 person mod-max \square 2 person | | | |
| Does this client l | have someone to assist them while attending the program? $\Box Y \Box N$ | | | |
| Transfers to chair: \Box Independent \Box Supervision \Box 1 person min \Box 1 person mod-max \Box 2 person | | | | |
| Ambulation: | \Box Independent \Box Supervision \Box 1 person min \Box 1 person mod-max \Box 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 be | een 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)