Outpatient/Ambulatory Rehab Referral Form*

The Outpatient/Ambulatory Rehab Referral Form is to be used for referrals to multiple rehab services provided by the GTA Rehab Network member organizations. This referral form is not intended to be used for referrals to medical/diagnostic services.

Note: The rehab programs/services offered by organizations may vary. For detailed information about programs offered by specific organizations, please refer to Rehab Finder at https://gtarehabfinder.ca/ or contact the organization directly.

The development of this new form has been supported by funding from the Toronto Central LHIN.

Please note:
- Acute care referrers in Toronto who use the E-Stroke Rehab Referral system for stroke rehab referrals should continue to use the electronic referral system for outpatient referrals.
- Use this form for all rehab populations except total joint replacements and acquired brain injury.
- Referrals for outpatient rehab following total joint replacements should use the TJR Outpatient Rehab Referral Form
- Referrals for patients with an Acquired Brain Injury should use the Toronto ABI Network’s ABI Community Profile, which can be downloaded at http://www.abinetwork.ca/community-profile.

Referrers, when making an outpatient rehab referral, consider ....

- If the client is able to access transportation to/from the program
- The inclusion / exclusion criteria of the rehab service to which you are applying. For example, wandering might be an exclusion criterion unless the client is accompanied by a caregiver.
  (Descriptions of rehab services / programs offered by GTA Rehab Network members can be found on Rehab Finder at https://gtarehabfinder.ca/)

Rehab referral receivers, when reviewing the Outpatient/Ambulatory Rehab Referral...

- If the client does not meet the eligibility criteria of your program, provide information on rehab services / program options offered by other programs/organizations or community services

For each referral...

- Complete each section of the referral form
- Fax the referral directly to the program/service you are requesting as per the organization’s intake process (Information on the application process is available on Rehab Finder at https://gtarehabfinder.ca/)

*Copies of the Outpatient / Ambulatory Rehab Referral Form can be downloaded from the GTA Rehab Network’s website at http://www.gtarehabnetwork.ca/outpatient-ambulatory.

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July 2015 / Rev June 2019
### OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

**SECTION 1: DEMOGRAPHIC INFORMATION**

| PATIENT’S NAME: | ______________________ | ______________________ |
|-----------------|-------------------------|
| LAST NAME, FIRST NAME | ______________________ |

- **GENDER**
  - □ M
  - □ F

- **DOB**
  - ______________________ (yyyy/mm/dd)

- **HOME ADDRESS**
  - Apt #
  - Postal Code
  - Home Telephone Number:
  - Alternate Phone Number:

- **HEALTH CARD NUMBER**
  - Version
  - Expiry Date (If available)

- **Province/Territory issuing Health Card:**
  - □ Ontario
  - Country/Province #
  - □ Other (Specify): ______________________

- **RESPONSIBILITY FOR PAYMENT (IF NOT OHIP)**
  - □ Private Insurer
  - □ WSIB
  - □ Auto Insurance
  - □ Veteran
  - □ Self Pay
  - □ IFH (Interim Federal Health Grant)
  - □ Out of Province

- **SPEAKS, UNDERSTANDS ENGLISH**
  - □ Yes
  - □ Minimal
  - □ No

  If Minimal/No, is family interpreter available?
  - □ Yes
  - □ No

  If no, interpreter is needed for what language? ______________________

- **SUBSTITUTE DECISION MAKER (SDM) / POWER OF ATTORNEY (POA) / EMERGENCY CONTACT INFORMATION**
  - Name:
  - Daytime Tel. No.
  - Relationship to Client:

- **FAMILY PHYSICIAN’S CONTACT INFORMATION:**
  - □ No Family Physician
  - Name:
  - Phone:
  - Fax:
  - Address:
  - Billing No. (if available):

**SECTION 2: REFERRAL INFORMATION**

- **REFERRAL DATE:**
  - ______________________ (YYYY/MM/DD)

- **REFERRAL CONTACT:** Contact name/position:
  - Phone: ( ) ________________

  Organization & Program/Service:

  Pager: ( ) ________________

- **CLIENT IS CURRENTLY:**
  - □ at home
  - □ other (specify)

- **IF CLIENT IS IN HOSPITAL:**
  - Date of Admission: ______ / ______ / ______ (YYYY/MM/DD)
  - Planned Date of Discharge: ______ / ______ / ______ (YYYY/MM/DD)

- **PRIMARY DIAGNOSIS:**

- **REHAB POPULATION:**
  - □ Amputee
  - □ Burns
  - □ Cardiac
  - □ General/Medical
  - □ Geriatric
  - □ MSK
  - □ Neuro
  - □ Oncology
  - □ Pulmonary
  - □ Spinal Cord
  - □ Trauma
  - □ Transplant
  - □ Other

- **REHAB SERVICE(S) REQUESTED:**
  - Note: Not all organizations provide all services listed below. For detailed information about programs offered by specific organizations, please refer to Rehab Finder at [https://gtarehabfinder.ca/](https://gtarehabfinder.ca/) or contact the organization directly.

  - □ Dietitian
  - □ Kinesiology
  - □ Nursing
  - □ Occupational Therapy
  - □ Physiatry
  - □ Physiotherapy
  - □ Psychiatry
  - □ Psychology
  - □ Speech Language Pathology / Communication
  - □ Speech Language Pathology / Swallowing
  - □ Social Work
  - □ Therapeutic Rec.
  - □ Other rehab services required (e.g. Seating Clinic, Vocational Rehab, Pain Management Clinic, Augmentative Communication/Writing Clinic etc.). Specify:

- **SPECIAL CONSIDERATIONS: (E.G. HOUSING, TRANSPORTATION, SOCIAL SUPPORT, VISUAL IMPAIRMENT, OTHER IDENTIFIED RISKS)**

  (If available, attach Social Work report)

- **IS CLIENT CURRENTLY RECEIVING OTHER REHAB SERVICES?**
  - □ No
  - □ Yes (specify)

- **REPORTS ATTACHED?**
  - (e.g. CT scan, OT/PT/SLP/SW notes etc.)
  - □ Yes
  - □ No
# OUTPATIENT/AMBULATORY REHAB REFERRAL FORM

## SECTION 3: REASON FOR REFERRAL

<table>
<thead>
<tr>
<th>PATIENT GOALS/TREATMENT PLAN</th>
<th>(Identify SMART goals – specific, measurable, attainable, realistic and timely)</th>
</tr>
</thead>
</table>

### BASIC PERSONAL ISSUES IDENTIFIED?

- [ ] No
- [ ] Yes (specify below)

  - Self-care
  - Toileting
  - Pain
  - Medication Management
  - Other: ____________________________

**Goals/Comments:**

### MOBILITY ISSUES IDENTIFIED?

- [ ] No
- [ ] Yes (specify below)

  - Ambulation:
    - [ ] Independent
    - [ ] Assistance
    - [ ] Supervision

  - Mobility Aid: ____________________________

  - Transfers:
    - [ ] Independent
    - [ ] Assistance
    - [ ] Supervision

  - If aid required: ____________________________

  - Activity Tolerance (specify):
    - [ ] Paresis/paralysis
    - [ ] Falls/history of falls
    - [ ] Other: ____________________________

**Goals/Comments:**

### BEHAVIOUR ISSUES IDENTIFIED?

- [ ] No
- [ ] Yes (specify below)

  - Wandering
  - Aggressiveness
  - Other: ____________________________

**Goals/Comments:**

### SWALLOWING ISSUES IDENTIFIED?

- [ ] No
- [ ] Yes (specify below)

  - [ ] Intact, regular diet
  - [ ] Dental soft diet
  - [ ] Minced diet
  - [ ] Pureed diet
  - [ ] Thickened fluids

**Goals/Comments:**

### COMMUNICATION ISSUES IDENTIFIED?

- [ ] No
- [ ] Yes (specify below)

  - [ ] Hearing
  - [ ] Vision
  - [ ] Language, comprehension
  - [ ] Language, expression
  - [ ] Speech Dysarthria
  - [ ] Speech Apraxia
  - [ ] Other (specify)

**Goals/Comments:**

### COGNITIVE ISSUES IDENTIFIED?

- [ ] No
- [ ] Yes (specify below)

  - [ ] Orientation
  - [ ] Participation
  - [ ] Judgment
  - [ ] Carryover/New Learning
  - [ ] Memory
  - [ ] Frustration tolerance
  - [ ] Other: ____________________________

**Goals/Comments:**

---

**COMPLETED BY:**

**PHONE:**

**DATE:**
**OUTPATIENT/AMBULATORY REHAB REFERRAL FORM**

**SECTION 4: RELEVANT MEDICAL INFORMATION**

<table>
<thead>
<tr>
<th>To be completed by Physician or Physician Designate</th>
<th>PATIENT’S NAME: ____________________________ (LAST NAME, FIRST NAME)</th>
</tr>
</thead>
</table>

**ALLERGIES:**
- □ No
- □ Yes (list):

**PRIMARY DIAGNOSIS & HISTORY OF PRESENTING ILLNESS** (relevant to reason for referral):
- Date of Injury/Onset: ____________________________ yyyy/mm/dd

**PAST MEDICAL / SURGICAL HISTORY** (relevant to rehab referral):
- Date of Surgery: ____________________________ yyyy/mm/dd

**RELEVANT MENTAL HEALTH HISTORY:**
- □ No
- □ Yes If yes, describe history, current status including suicide risk, provide recent consult notes and details of follow-up arrangements:

Followed by ACT Team/Case Manager?
- □ No
- □ Yes (Specify contact information):

**SUBSTANCE ABUSE:**
- History of Substance Abuse: □ No □ Yes □ History not available
- Current Substance Abuse: □ No □ Yes □ Not known
- Substance Abuse Treatment Recommended: □ No □ Yes

**INFECTIOUS DISEASE:**
- □ No
- □ Yes (specify below) □ Unknown

Does individual currently have:
- MRSA: □ No □ Yes Location: ____________________________
- VRE: □ No □ Yes Location: ____________________________
- C-Difficile: □ No □ Yes Other(specify):

**WEIGHT BEARING STATUS AS ORDERED BY MD:**
- □ No restrictions

Left: □ Right: □ □ As tolerated □ Partial ______% □ Touch weight bearing □ Non weight bearing

Precautions and restrictions: ____________________________ Date to become weight bearing: ____________________________

**CARDIOVASCULAR & PULMONARY HISTORY:** (As applicable)

- □ None known

Known Cardiac Risk Factors:
- □ Hypertension □ Diabetes I / II
- □ Family History □ Hyperlipidemia
- □ Smoking

<table>
<thead>
<tr>
<th>Pacemaker/ICD</th>
<th>□ No □ Yes</th>
<th>If yes, name of pacer clinic: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous CVA</td>
<td>□ No □ Yes Pulmonary Disease □ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Peripheral Vascular Disease</td>
<td>□ No □ Yes Myocardial Infarction □ No □ Yes</td>
<td></td>
</tr>
<tr>
<td>Heart Failure</td>
<td>□ No □ Yes Atrial Fibrillation/Other arrhythmias □ No □ Yes</td>
<td></td>
</tr>
</tbody>
</table>

**SAFE TO PARTICIPATE IN WARM THERAPEUTIC POOL (HYDROTHERAPY) IF THERAPIST INDICATES THIS IS NECESSARY?**
- □ No □ Yes

**HAS THE MINISTRY OF TRANSPORTATION BEEN NOTIFIED OF PATIENT’S MEDICAL STATUS?**
- □ No □ Yes

**REFERRING PHYSICIAN:** I authorize a referral for this individual for the services specified.

<table>
<thead>
<tr>
<th>Name: ____________________________</th>
<th>Phone: ____________________________</th>
</tr>
</thead>
</table>

Signature: ____________________________ Date: ____________________________ (yyyy/mm/dd)

Billing No. (if available): ____________________________ Hospital: ____________________________
SECTION 5: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION
To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager)

□ I agree that ________________________ ______________________ may release my personal health information to make a referral.

(Referral source disclosing information)

Organization(s) referred to:

- Baycrest
- Bridgepoint Active Healthcare/Sinai Health System
- Halton Healthcare Services
- Lakeridge Health
- Markham Stouffville Hospital
- Mackenzie Health
- North York General Hospital
- Providence Healthcare/Unity Health Toronto
- St. John’s Rehab Hospital/Sunnybrook Health Sciences Centre
- Scarborough Health Network
- Southlake Regional Health Centre
- Sunnybrook Health Sciences Centre
- St. Joseph’s Health Centre /Unity Health Toronto
- St. Michael’s /Unity Health Toronto
- Toronto Rehab/University Health Network
- Trillium Health Partners
- University Health Network
- West Park Healthcare Centre

Other (specify): ________________

To be completed for all referrals:

Print Name of Patient: __________________________________________________________________________________________________________

Signature of Patient/Substitute: __________________________________________________________________________________________________

If unable to obtain signature, has verbal consent been obtained? □ Yes

Witness: __________________________________________

(Print name)

(Signature)

Name of Substitute: (Print name) __________________________________________________________________________________________

Relationship to patient, if signed by Substitute: ______________________________________________________________________________

□ Yes, an interpreter was used when consent was obtained.
□ No interpreter was required.

Date (YYYY/MM/DD) ____________________