GRAND RIVER HOSPITAL

Neuro Rehabilitation Clinic & Geriatric Rehabilitation Clinic Referral Form

Grand River Hospital, Freeport Site: 3570 King St East Kitchener, ON N2A 2W1
Phone: 519-894-8340 **Fax:** 519-894-8307

NEURO REHABILITATION CLINIC	GERIATRIC REHABILITATION CLINIC
• The individual has an acute neurological (CNS) diagnosis • Acute change in status of the neurological diagnosis, or • Neurological diagnosis impacting recovery from an acute medical change, and • Requires individual/ intensive therapy to attain functional goals.	• The individual is having increasing difficulty functioning as a result of complex medical issues, and • Is generally an older individual.

Additionally the client must meet all of the following criteria for both programs:

- ✓ Requires selective occupational therapy, physiotherapy, recreation therapy, registered dietitian, social work, and/or speech-language therapy to attain functional goals.
- ✓ Medically stable.
- ✓ Able to tolerate travel to and from the clinic in addition to therapy.
- ✓ Rehabilitation needs can be met within the clinic.
- ✓ Demonstrates sufficient cognitive skills to participate in goal setting and to be able to integrate new learning into daily life.
- ✓ Minimum of 16 years of age.
- ✓ Physician referral required for assessment and treatment.

Program Requested

❒**Neuro Rehabilitation Clinic** ❒**Geriatric Rehabilitation Clinic** ❒**To be determined by team**

Patient Identification

Last name	First name	Initial	Birth Date (year / month / day)
Address	City	Province	Postal Code
Home Phone:	Business/Cell Phone	Health card #	Sex ❒ Male ❒ Female

Alternate Contact ❒Emergency Contact ❒Substitute Decision Maker ❒Power of Attorney

Last name	First name	Relationship
Home Phone	Business Phone	Cell Phone

To arrange appointments contact: ❒Patient ❒Alternate Contact ❒Other:_____

❒Patient/Substitute Decision Maker has consented to messages being left at the above phone numbers

Services Requested

❒ Occupational Therapy ❒ Physiotherapy ❒ Recreation Therapy ❒ Social Work ❒ Speech Language Pathology ❒ Dietitian

REFERRING DIAGNOSIS	RELEVANT PAST MEDICAL HISTORY	REHABILITATION GOALS (Current Status, Expected outcomes, etc.)
Date of onset:	*** EXPECTED DISCHARGE DATE (if still in hospital):**	

***Please Note:** Recent discharge summaries and any relevant medical reports must be attached*

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Does this person have a *current* ARO infection? ❒Yes ❒No (Please Specify): ❒MRSA ❒VRE ❒C.Diff ❒ESBL

Driving Information *Please discuss any medical/functional concerns with the patient prior to submitting this referral*

Is the patient medically fit to drive? ❒Yes ❒No ❒Uncertain

Has the Ministry of Transportation been informed the patient has a medical condition that may affect their ability to drive?

❒Yes ❒No ❒Uncertain

Medication Profile (Please list or attach current medication list with dosages)

Allergies (describe allergic reaction)

❒ None known ❒ Drug allergies _____ ❒Food or Environmental allergies_____

Diet (if other than regular)

Transportation (How will patient get to the Grand River Hospital-Freeport Site Rehabilitation Clinic?)

❒Family/Friend will drive ❒Mobility Plus/Kiwanis Transit ❒Bus or Taxi ❒ Patient will drive self

Special Considerations / Comments

❒ Referral form was completed with client/substitute decision maker, and reason for referral has been discussed.

Referral Source

Last name	First name	Office phone number
Discipline	Name of service	Date year / month / day

Family Physician

Last name	First name	Phone Number:
		Fax Number:

Referring Physician

Last name	First name	Phone Number:
		Fax Number:

Physician Signature (REQUIRED)

	Date year / month / day

Fax Completed Form (3 pages) to - Fax: 519-894-8307

Please direct any questions to - Phone: 519-894-8340

NOTE: Please attach medication profile and all relevant reports.

All incomplete referral forms will be returned to referral source for completion

Please complete Page 3, fax it, and then provide the original copy to the patient.

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Patient Information Letter

Dear Patient:

You have been referred to the:

☐ Neuro Rehabilitation Clinic ☐ Geriatric Rehabilitation Clinic

At Grand River Hospital – Freeport Site
We are located at 3570 King Street East, Kitchener
On the first floor of Union Terrace

Your first appointment has been arranged for:

Date: _____ **Start Time: _____**

Type of therapy: **End Time:**

Please bring your Health Card, an up-to-date medication list, and this form to your first visit. We ask that you arrive 10 minutes early to register with our secretary.

Parking: The parking lot is located behind the building and you may pay at the exit with cash or coins. If interested in obtaining a longer- term permit you can purchase a parking pass at the Security office.

Directions: Upon entering the main entrance of the building, turn right and proceed down the hall until you see the Union Terrace sign. Turn right at the elevators and proceed through the doors to our waiting room. Please register with our secretary.

For additional information or to reschedule your assessment time, please call our secretary at 519-894-8340.

Therapists or referrer: please check the following items that have been initiated or completed:

☐ Traverse Independence
☐ Stroke Recovery Association
☐ Neuro exercise program at the YMCA
☐ Neuropsychological assessment
☐ Private therapy_____
☐ CCAC: ☐ OT ☐ PT ☐ SLP ☐ PSW
☐ Ministry of Transportation notified
☐ Client has been advised not to drive at this time
☐ Hamilton ABI program
☐ Low vision clinic at U of W
☐ Lifeline
☐ Meals on Wheels
☐ Mobility Plus
☐ Other_____
☐ Other_____