PETERBOROUGH REGIONAL HEALTH CENTRE

Stroke Rehabilitation Program

Outpatient Rehabilitation Referral Form

1 Hospital Drive Peterborough, ON K9J 7C6
t: 705-743-2121 x. 2828 | f: 705-876-5840

PATIENT LABEL

Please ensure that the referral is fully completed and supporting documents attached before faxing to the department.

Date of referral (DD/MM/YYYY): _____

Patient Name:	Date of Birth (DD/MM/YYYY):	Health Card #:

Address:	TELEPHONE Home: _____ Work: _____ Cell: _____
Diagnosis:	Date of Stroke Onset: _____ Last Admission Date: _____

☐ OT: Reason for referral: ☐ Cognition/Perception ☐ Upper Extremity
☐ Other: _____

☐ PT: Reason for referral: ☐ Transfers ☐ Strength ☐ Balance ☐ Abnormal Gait ☐ Gait Aid Progression
☐ Other: _____

☐ SLP: Reason for referral: ☐ Aphasia ☐ Apraxia of Speech ☐ Dysarthria
☐ Other: _____

Health History/Precautions:

☐ Arthritis	☐ Diabetes	☐ Dyslipidemia	☐ Other:
☐ Allergies	☐ COPD/Asthma	☐ Epilepsy	_____
☐ Cancer: _____	☐ HTN	☐ Liver Disease	_____

Does your patient have any pre-exsisting health conditions that would make exercising unsafe, difficult or high risk? ☐ NO ☐ YES, please note: _____

Will the patient be referred to Homecare Therapy Service upon discharge? ☐ Y ☐ N
Comments: _____

Attached are the following results:

☐ Imaging reports (MRI, CT-CTA)	☐ Stroke Discharge Notes (OT, PT, SLP, Hospitalist)
☐ Home Care Progress/Discharge Notes	☐ Resent Consultation Notes
☐ Raw Data from Cognitive/Perceptual Screens	☐ Other: _____

Physician/NP Name (please print):	Physician/NP Telephone:
I verify that the above named patient is appropriate for the Out-Patient Stroke Rehabilitation Program **Signature of Referring Physician/NP:**	Date (DD/MM/YYYY):

FOR OFFICE USE:

K# _____ Account #_____ Initials _____

Form #7059, Revised, October 2024