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:	Diagnosis:	
TELEPHONE Home: _____ Work: _____ Cell: _____	Date of Stroke Onset (DD/MM/YYYY): _____ Last Admission Date (DD/MM/YYYY): _____	

☐ **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: _____

☐ **SW: Reason for referral:** ☐ Community Referral ☐ Adjustment to Illness ☐ Financial Resources ☐ 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: _____

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: _____

Practitioner's Name (please print):	Practitioner's 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 _____