Office Use Only:
Date Referral Received:____________

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Referral Form

Oxford___ Middlesex___ S/W Norfolk___ Elgin___ Huron___ Perth___ Grey___ Bruce___

Client Information:

Name:	Health Card #:	Registration #:
Address:		Postal Code:
Phone:	Date of Birth (yy/mm/dd):	Sex: __M __ F

Marital Status: ___Single ___Married ___Divorced ___Separated ___Common-law _____Widow(er)

Preferred Language: _____ English _____ French ____ Other (please indicate): ______________________

Next of Kin:	Telephone:

Contact Information: (Who should we make first contact with if not the client?) Same as above: __Yes __No

Name:	Relationship:

Current Status:

Has the client been informed and consents to referral? ___Yes ___No

Is client currently in hospital? ___Yes ___No	Facility:
Admission to Hospital (yy/mm/dd):	Admission FIM (or alpha FIM if available):
Expected Date of Discharge (yy/mm/dd):	Discharge FIM (if available):

Have you attached any relevant reports/discharge summaries? ____Y ____N

Expected Discharge Destination: ____Home ____ LTC _____ Other(If other please describe):

____

Physician Information:

Attending Physician Name:	Phone:
Family Physician Name:	Phone:
Physician Signature (optional):	

History:

Date of stroke: (yy/mm/dd)	Type of stroke (if known or for assistance, please ask your health care provider): ☐ Ischaemic (clot) ☐ Hemorrhagic (bleed) ☐ Not known	Diet: Does client follow a special diet? ___y ___n ☐ Weight Loss ☐ Other – Please describe ☐ Weight Gain ☐ Diabetic ☐ Modified Texture (i.e., pureed, minced, thick fluids ____________________

Presenting Difficulties (What areas are you having difficulty with? Please check all that apply.):

☐ difficulty with arm and hand function
☐ difficulty with walking and getting around
☐ difficulty with vision and perception
☐ talking and understanding
☐ taking care of myself
☐ support to care for my loved one
☐ concerned about my finances
☐ eating well and preparing meals
☐ household tasks
☐ difficulty swallowing
☐ safety in the home
☐ adjusting to life after stroke
☐ managing emotional changes
☐ I want to learn more about my stroke
☐ impulsiveness
☐ fatigue
☐ difficulty with memory
☐ boredom
☐ learn ways to improve my quality of life
☐ I want to learn more about community resources
☐ other: ____

Priorities for service:

Based on the difficulties listed above, I want to improve in these areas (rehab goals):
(to help us better understand your priorities, please indicate your top three)

1.

2.

3.

Is there anything else you think we should be aware of?
____
____

Relevant Medical/Psychiatric History (Alzheimer's, Parkinson's, Dementia…) *Attach Medication List if available*:
____
____
____
____

Reaction to Medication __Y __N: Latex or Environmental Reaction __Y __N:
If yes please describe:

Is there a history of: ☐ Substance use ☐ Criminal offences or charges
please describe:

Referral Information:

Date of referral : (yy/mm/dd)	**Referral Source:** (Name of Person filling out the form - indicate agency if applicable)

Have referrals been made to other agencies/services? (i.e., CCAC, Adult Day Programs….) **Please Specify and Indicate Service Provider Name Contact Number(s):** ____
____