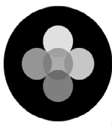

Lakeridge Health

# Physiatry Stroke Referral

1 Hospital Court, Oshawa, ON
Tel: 905–576–8711 ext.33792
Fax: 905–721–7797

Patient's Name:________________________
DOB:_____________ Gender: ☐ M ☐ F
Health Card #:________________________
Address:____________________________
Phone number:________________________
(Label if appropriate and has all information)

Date of Referral: ____________________________________________

Referring Clinician: ________________________ / ____________________________
Please Print Name Signature

CPSO# _______________ OHIP Billing # __________________ (residents use attending physician #s)

**PATIENT MUST HAVE HAD A CONFIRMED STROKE**

**REASON FOR REFERRAL:**

☐ Spasticity/muscle stiffness

| | | | |
|---|---|---|---|
| Upper limb | ☐ Right | ☐ Left | ☐ Both |
| Lower limb | ☐ Right | ☐ Left | ☐ Both |

☐ Stroke–Related Neuropathic Pain
☐ Functional Assessment (gait aid, bracing)
☐ Coordinate Stroke–Specific outpatient care (government funded outpatient therapy available only for recent stroke i.e. 3 months)
☐ Counsel patient/family on prognosis
☐ Post–stroke Driving Assessment
☐ Post–stroke Return to Work Assessment

Other (please specify):________________________________________ (MD to review)

**PERTINENT LAB/IMAGING FINDINGS:**

For a patient who was not admitted to Lakeridge Health for stroke–related care, please include stroke–related:

☐ Discharge note ☐ Imaging (MRI/CT Brain Scan) ☐ Lab work

If not available, please indicate reason:

☐ MRI contraindicated
☐ MRI pending Booked date: __________ Location: _________________
Other (specify): ____________________________

**Please FAX completed referral and documents to 905–721–7797**

REF0064.1 APPROVED 20SEP2019
☐ Harmonized