



**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 Fax number

CPSO/CNO # \_\_\_\_\_ 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:**

Patients who were not admitted to Lakeridge Health, please include:

- 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**

