Lakeridge Health

Ambulatory
Rehabilitation
Centres

Please fax completed form to (905) 665−2414

The Ambulatory Rehabilitation Centre **Neurological Rehabilitation** services include the regulated health professionals listed below. Should we determine that your patient requires the assistance of an additional service(s) that has not been indicated, we will facilitate a referral to the appropriate health discipline(s) automatically.

Is this patient currently a Lakeridge Health Inpatient? ☐ No ☐ Yes Unit _____

Please indicate below which service(s) your patient requires.

Health Disciplines Referral	
☐ Physiotherapy	If you do not wish for an automatic health discipline referral, please initial here. **MD Initials** _____
☐ Occupational Therapy	
☐ Speech Language Pathology, Communication	
☐ Social Work	

Please complete all sections of the referral and attach all related consultations.			
First Name:	Last Name:	Phone:	
Address:	City:	Alternate:	
Province:	Postal Code:	☐ Male	☐ Female
DOB:	Health Card No.:		

Primary Diagnosis (please include details of stroke)

☐ Stroke − Ischemic _____

☐ Stroke − Intracerebral Hemorrhage _____

☐ Stroke − Unable to Determine _____

☐ Other Primary Neurological Diagnosis: _____

Date of onset:		
Person initiating referral:	Phone:	Fax:
Referring Facility:	Person still in hospital? ☐ Yes ☐ No	**Discharge Date:**
Family Physician:	Phone:	Fax:
Allergies?	Additional Information:	

Infection Prevention

Antibiotic Resistant Organisms:	Positive? ☐ Yes ☐ No	If yes, please indicate ☐ VRE ☐ MRSA ☐ CRE
	Exposure? ☐ Yes ☐ No	If yes, please indicate ☐ VRE ☐ MRSA ☐ CRE

Please answer the following:	Yes	No
Has this person had therapy intervention recently? Please attach therapy discharge summaries.	☐	☐
Is this person receiving other services in the home?	☐	☐
Has this person had a recent consultation with a specialist related to the primary diagnosis? If yes, please attach consult notes.	☐	☐

Referring Physician's Name (Please Print)	Physician's Signature
Billing Number	Date

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