MUSKOKA ALGONQUIN HEALTHCARE

OUTPATIENT STROKE REHABILITATION PROGRAM REFERRAL

PATIENT INFORMATION (required)			
Patient Name:		Preferred Name:	
DOB: yyyy/mm/dd		HCN + Version Code:	
Home Address:			
Primary Phone Number: ☐ Landline ☐ Cell		Alternate Phone Number: ☐ Landline ☐ Cell	
Emergency Contact Name/Phone Number:		Relationship to Patient:	
SDM/POA Contact Name/Phone Number:		Relationship to Patient:	
Family/Primary Care Provider Name:		☐ No Family/Primary Provider	
Allergies (if known):		Communicable Illness: MRSA VRE MERS C Diff COVID Other: specify	
Has Ministry of Transportation been notified of patient medical status? ☐ No ☐ Yes			
Transportation to the program has been arranged: ☐ No ☐ Yes			
REFERRAL INFORMATION (required)			
Reason for referral:			
☐ Balance	☐ Gait	☐ Perception	☐ Stroke Education
☐ Cognition/Cognitive Communication	☐ Lower Extremity	☐ Sensory	☐ Upper Extremity
☐ Finances	☐ Mood/Depression	☐ Speech	☐ Other:
Referring Provider Name/CPSO/Phone Number:			
Date of Stroke: yy/mm/dd			
Is patient currently in hospital: ☐ No (go to next line) ☐ Yes Name of Facility: Admit Date: yyyy/mm/dd			Anticipated discharge date: yyyy/mm/dd
Was patient discharged from a rehab program? ☐ No ☐ Yes Name of Facility:			Date of Discharge: yyyy/mm/dd
Mobility: ☐ Independent ☐ Supervision only ☐ 1 person assist ☐ 2 person assist **Equipment**:			
REHABILITATION SERVICES REQUESTED (required) Check at least one service and may select all			
☐ Dietician (RD)	☐ Physiotherapy (PT)		
☐ Nursing (RN)	☐ Social Work (SW)		
☐ Occupational Therapy (OT)	☐ Speech Language Pathology (SLP)		
FIM SCORES			
Alpha FIM (*REQUIRED*):			
Rehab Admission FIM:			
Discharge FIM:			
Other Services			
Is patient currently receiving other rehab services? ☐ No ☐ Yes If yes, please specify:			
Is patient currently receiving home care service? ☐ No ☐ Yes If yes, please specify:			
Is patient currently a SASOT client? ☐ No ☐ Yes			
MEDICAL HISTORY INFORMATION (incl any information that may not be readily available on Connecting Ontario or other patient portal)			
Primary Dx/Hx of Presenting Illness (relevant to reason for referral):			
Past Medical/Surgical/Behaviour Health Hx (relevant to rehab referral):			
Reports attached (CT, Allied Health notes, etc.) ☐ No ☐ Yes			
Signature of Referring Provider:			Date: *yy/mm/dd*

FAX/SCAN this completed referral form, along with supporting documentation to: outpatientstrokerehab@mahc.ca