

**Stroke Recovery Clinic  
Outpatient Rehabilitation Referral Form**

1000 DePalma Drive, Cobourg, ON K9A 5W6

T: 905 372 6811 Ext: 3768 F: 905 373 6911

Affix Patient Label.  
Please do not write in this area.

Please ensure that the referral is fully completed (2 pages) and supporting documents attached before faxing.

**Date of referral** {DD/MM/YYYY}: \_\_\_\_\_

Patient Name:	Date of Birth (DD/MM/YYYY):	Health Card #:
Address:	Diagnosis:	
	Date of Stroke Onset (DD/MM/YYYY):	
Patient Telephone Home: _____ Cell: _____	Emergency Contact Name: _____ Home/cell #: _-_____	
<b>Referred From:</b> <input type="checkbox"/> <b>Acute Care</b> <input type="checkbox"/> <b>Inpatient Rehab Program</b> <input type="checkbox"/> <b>Primary Care Provider</b> <input type="checkbox"/> Other: _____		
<input type="checkbox"/> <b>OT</b> <b>Reason for referral:</b> <input type="checkbox"/> Cognition <input type="checkbox"/> Perception <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Other: _____		
<input type="checkbox"/> <b>PT</b> <b>Reason for referral:</b> <input type="checkbox"/> Transfers <input type="checkbox"/> Strength <input type="checkbox"/> Balance <input type="checkbox"/> Gait training <input type="checkbox"/> Other: _____		
<input type="checkbox"/> <b>SLP</b> <b>Reason for referral:</b> <input type="checkbox"/> Aphasia <input type="checkbox"/> Apraxia of Speech <input type="checkbox"/> Dysarthria <input type="checkbox"/> Other: _____		
<b>Health History/Precautions:</b> <input type="checkbox"/> Cardiovascular conditions (e.g. pacemaker, hypertension) Please specify _____ <input type="checkbox"/> Lung conditions (e.g. COPD, asthma) Please specify _____		

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**Health History/Precautions Continued:**

- Musculoskeletal conditions (e.g. arthritis, osteoporosis, low back pain)  
Please specify \_\_\_\_\_
- Previous surgeries (e.g. joint replacement).  
Please specify \_\_\_\_\_
- Cancer: \_\_\_\_\_
- Epilepsy    Diabetes    Syncope/Fainting Episodes    History of Falls    Osteoporosis
- Other: \_\_\_\_\_

**Does your patient have any other pre-existing health conditions that would make exercising unsafe, difficult, or high risk?**

- NO    YES, please specify: \_\_\_\_\_

**AlphaFIM score** (if applicable): \_\_\_\_\_ Date of assessment: \_\_\_\_\_

**Attached are the following results:**

- Imaging reports (MRI, CT-CTA)
- Stroke Discharge Notes (OT, PT, SLP, Physician, NP)
- Home Care Progress/Discharge Notes
- Recent Consultation Notes
- Raw Data from Cognitive/Perceptual Screens
- Other. Please Specify \_\_\_\_\_

Referring Provider's Name (please print):

Provider's Telephone:

By signing, I verify that the above-named patient is appropriate for outpatient stroke rehabilitation.

**Signature of Referring Provider:**

**Date (DD/MM/YYYY):**

**FOR OFFICE USE:**

K# \_\_\_\_\_ Account #. \_\_\_\_\_ Initials \_\_\_\_\_