NHH
Northumberland Hills Hospital

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 #: _____	

Referred From: ☐ **Acute Care** ☐ **Inpatient Rehab Program** ☐ **Primary Care Physician/NP**
☐ Other: _____ **Note:** Referral must be submitted by a Physician or NP

☐**OT**
Reason for referral:
☐ Cognition/Perception ☐ Upper Extremity
☐ Other: _____

☐ **PT**
Reason for referral:
☐ Transfers ☐ Strength ☐ Balance ☐ Abnormal Gait ☐ Gait Aid Progression
☐ Other: _____

☐ **SLP**
Reason for referral:
☐ Aphasia ☐ Apraxia of Speech ☐ Dysarthria
☐ Other: _____

☐ **Patient meets eligibility criteria for outpatient stroke rehabilitation program**

18 years of age or older	Less than one year since experiencing a stroke
Resident of Ontario	Currently residing in home or retirement home
Achievable/meaningful rehabilitation goals	Willing and able to participate in intensive rehab

Health History/Precautions:

Form **2060** Rev **June 2026**

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☐ Cardiovascular conditions (e.g. pacemaker, hypertension)
Please specify_____
☐ Lung conditions (e.g. COPD, asthma)
Please specify_____
☐ 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 Physician / Nurse Practitioner 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):**

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