COMMUNITY Stroke Rehabilitation TEAM

Office Use Only:
Date Referral Received:_____

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Referral Form

Oxford___ Middlesex___ S/W Norfolk___ Elgin___ Huron___ Perth___ Grey___ Bruce___

Client Information:		
Name:	Health Card #:	Registration #:
Address:		Postal Code:
Phone:	Date of Birth (yy/mm/dd):	Sex: __M __ F
Marital Status: ___Single ___Married ___Divorced ___Separated ___Common-law _____Widow(er)		
Preferred Language: ____ English ____ French ___ Other (please indicate): _____		
Next of Kin:	Telephone:	
Contact Information: (Who should we make first contact with if not the client?) Same as above: __Yes __No		
Name:	Relationship:	

Current Status:	
Has the client been informed and consents to referral? ___Yes ___No	
Is client currently in hospital? ___Yes ___No	Facility:
Admission to Hospital (yy/mm/dd):	Admission FIM (or alpha FIM if available):
Expected Date of Discharge (yy/mm/dd):	Discharge FIM (if available):
Have you attached any relevant reports/discharge summaries? ____Y ____N	
Expected Discharge Destination: ____Home ____ LTC _____ Other(If other please describe): _____	

Physician Information:	
Attending Physician Name:	Phone:
Family Physician Name:	Phone:
Physician Signature (optional):	

History:

Date of stroke: (yy/mm/dd)	Type of stroke (if known or for assistance, please ask your health care provider): □ Ischaemic (clot) □ Hemorrhagic (bleed) □ Not known	Diet: Does client follow a special diet? ___y ___n □ Weight Loss □ Other – Please describe □ Weight Gain □ Diabetic □ Modified Texture (i.e., pureed, minced, thick fluids _____

Presenting Difficulties (What areas are you having difficulty with? Please check all that apply.):

□ difficulty with arm and hand function
□ difficulty with walking and getting around
□ difficulty with vision and perception
□ talking and understanding
□ taking care of myself
□ support to care for my loved one
□ concerned about my finances
□ eating well and preparing meals
□ household tasks
□ difficulty swallowing
□ safety in the home
□ adjusting to life after stroke
□ managing emotional changes
□ I want to learn more about my stroke
□ impulsiveness
□ fatigue
□ difficulty with memory
□ boredom
□ learn ways to improve my quality of life
□ I want to learn more about community resources
□ other: _____

Priorities for service:

Based on the difficulties listed above, I want to improve in these areas (rehab goals):
(to help us better understand your priorities, please indicate your top three)

1.
2.
3.

Is there anything else you think we should be aware of?

_____

_____

Relevant Medical/Psychiatric History (Alzheimer's, Parkinson's, Dementia…) *Attach Medication List if available*:

_____

_____

_____

_____

Reaction to Medication __Y __N: Latex or Environmental Reaction __Y __N:
If yes please describe:

Is there a history of: □ Substance use □ Criminal offences or charges
please describe:

Referral Information:

Date of referral **:** (yy/mm/dd)	**Referral Source:** (Name of Person filling out the form - indicate agency if applicable)

Have referrals been made to other agencies/services? (i.e., CCAC, Adult Day Programs….) **Please Specify and Indicate Service Provider Name Contact Number(s):** _____

_____

St Joseph's Health Care London · HPHA Huron Perth Healthcare Alliance · Grey Bruce Health Services · Stroke Network Southwestern Ontario — Serving Erie St. Clair and South West LHINs