

Tel: 416-224-6948
Fax: 416-226-3358

285 Cummer Avenue
Toronto, ON M2M 2G1
www.stjohnsrehab.com



**AMBULATORY CARE DEPARTMENT
OUTPATIENT REFERRAL FORM**

PATIENT'S NAME:	D.O.B.:	PHONE:	LANGUAGES SPOKEN:
ADDRESS:		CAREGIVER CONTACT:	
OHIP NO: (include Version Code)		WSIB CLAIM NO:	
PRESENTLY IN HOSPITAL? <input type="checkbox"/> NO <input type="checkbox"/> YES FACILITY / ROOM NUMBER:			

***** PLEASE PROVIDE, AS PART OF YOUR REFERRAL, RELEVANT MEDICAL/THERAPY REPORTS *****
***** TRANSPORTATION MUST BE ARRANGED BY PATIENT OR CAREGIVERS*****

PROGRAM REQUIRED

- Amputee
- Burns
- Orthopaedic

- Neurological
- Organ Transplant

SERVICES REQUIRED

- Nursing
- Occupational Therapy
- Physiotherapy

- Speech-Language Pathology
- Social Work

CURRENT PRIMARY DIAGNOSIS: _____

DATE OF ONSET: _____ **DATE OF SURGERY:** _____ **DISCHARGE DATE:** _____

MOST RECENT TREATMENT PROGRAM: (Date(s) and Location) _____

CURRENT FINDINGS (include dates where applicable): _____ **WEIGHT BEARING STATUS:** _____

- Cardiac Condition
- Diabetes
- Epilepsy
- History of Cancer (please specify): _____
- Arthritis (specify type): _____
- Allergies (please specify): _____
- Hypertension
- Pacemaker
- Vascular Disease
- Other: _____

RISK / SAFETY ISSUES: _____

RELEVANT CLINICAL FINDINGS:

REHABILITATION GOALS:

REFERRING PHYSICIAN'S NAME: _____ **PHONE:** _____

REFERRING PHYSICIAN'S SIGNATURE: _____ **DATE:** _____

PHYSICIAN'S ADDRESS: _____ **FAX:** _____

FAMILY PHYSICIAN: _____ **PHONE:** _____ **FAX:** _____