

**OUTPATIENT REFERRAL
FORM**

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

PATIENT'S NAME:	D.O.B.:	OHIP NUMBER: (Include Version Code)	
PATIENT'S ADDRESS:			PHONE #:
CAREGIVER NAME/CONTACT INFO:		LANGUAGES:	<input type="radio"/> MALE
		REQUIRES INTERPRETER: <input type="radio"/> YES	<input type="radio"/> FEMALE
PRESENTLY IN HOSPITAL <input type="radio"/> NO <input type="radio"/> YES	ROOM NUMBER:	DISCHARGE DATE:	

PROGRAM REQUIRED

<input type="radio"/> AMPUTEE	<input type="radio"/> BURNS	<input type="radio"/> NEUROLOGY	<input type="radio"/> ORGAN TRANSPLANT	<input type="radio"/> ORTHOPAEDIC	<input type="radio"/> TRAUMA
<input type="radio"/> FALLS PREVENTION	<input type="radio"/> WSIB WSIB CLAIM # :	<input type="radio"/> M.V.C. M.V.C. CLAIM # :			

CURRENT PRIMARY DIAGNOSIS: _____

DATE OF ONSET: _____

DATE OF SURGERY/TYPE _____

WEIGHT BEARING STATUS: _____

INSURANCE COMPANY NAME AND ADDRESS:

ADJUSTER NAME:	PHONE #:
	FAX #:

ISOLATION: NO YES _____

MEDICAL HISTORY: Cardiac Condition Stroke Diabetes Hypertension Pacemaker Seizures

Vascular Disease Arthritis (specify) _____ Other _____

SERVICES REQUIRED: Fall Prevention Nursing Occupational Therapy Psychology Psychiatry Physiotherapy

Social Work Other _____

RELEVANT CLINICAL FINDINGS/REHABILITATION GOALS: (ie. Prosthetic Provider, Cognitive Assessment)

PHYSICIAN'S ORDERS FOR NURSING:

REFERRING FACILITY: _____

REFERRING PHYSICIAN'S NAME/SIGNATURE: _____ / _____

REFERRING PHYSICIAN'S PHONE #: _____ FAX #: _____

SURGEON/SPECIALIST'S NAME: _____ FAX#: _____

CLINICIAN'S NAME: _____ DATE: _____