COMMUNITY Stroke Rehabilitation TEAM

Office Use Only:

Date Referral Received:_____

ID#: _____

Referral Form

CENTRAL INTAKE OFFICE
Parkwood Institute – Main Building
P.O. Box 5777, STN B, London, ON
Telephone: (519) 685-4292 ext. 45034 Toll Free: 1-866-310-7577
Fax: (519) 685-4802

Please indicate the county you are referring for:

Oxford □ Middlesex □ S/W Norfolk □ Elgin □ Huron □
Perth □ Grey □ Bruce □

Client Information:

Name:	Health Card #:	Registration #:
Address:	City/Town:	Postal Code:
Phone:	Date of Birth (yy/mm/dd):	Sex: □M □F

Marital Status: □ Single □ Married □ Divorced □ Separated □ Common-law □ Widow(er)

Work Status: □ retired □ working □ other

Preferred Language: □ English □ French □ Other (please indicate):

Next of Kin:	Telephone:	Relationship:

Alternate Contact Information: (Who should we make first contact with if **not** the client?) :

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 (if available):
Expected Date of Discharge (yy/mm/dd):	Discharge FIM (if available):

Have you attached any relevant reports/discharge summaries? □ Y □ N □ will forward later

Expected Discharge Destination: □ Home □ LTC □ Other (If other please describe):

Status of Driver's License: □ valid □ suspended □ letter sent to MTO by physician □ unknown

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):	Diet: Does client follow a special diet? ☐Y ☐N
	☐ Ischaemic (clot) ☐ Hemorrhagic (bleed) ☐ Not known	☐ Weight Loss/Gain ☐ Diabetic ☐ Modified Texture (i.e., pureed, minced, thick fluids) ☐ Other:

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
- ☐ learn more about community resources
- ☐ eating well and preparing meals
- ☐ household tasks
- ☐ difficulty swallowing
- ☐ safety in the home
- ☐ adjusting to life after stroke
- ☐ managing emotional changes
- ☐ learn more about my stroke
- ☐ learn to reduce risk of another stroke
- ☐ impulsiveness
- ☐ fatigue
- ☐ difficulty with memory
- ☐ boredom
- ☐ learn ways to improve my quality of life
- ☐ other: _____

Priorities for service: **(in the client's own words where possible)**

Based on the difficulties listed above, I want to improve in these top 3 areas (rehab goals):

1.

2.

3.

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

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

Reaction to Medication ☐Y ☐N:
If yes please describe:

Latex or Environmental Reaction ☐Y ☐N:

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)

Currently involved with SW LHIN?: ☐Y ☐N **Please Specify and Indicate Name Contact Number(s):**

Other agencies/services? (i.e., adult day programs, privately paid therapies, transportation services….):

Email Address: communitystrokerehab@sjhc.london.on.ca