COMMUNITY Stroke Rehabilitation TEAM

Referral Form

Office Use Only:

Date Referral Received:_____

ID#: _____

Thames Valley
T. 519-685-4292 x 45034
F. 519-685-4802
Elgin Oxford Middlesex SW Norfolk

Huron-Perth
T. 519-527-8425
F. 519-272-8242

Grey-Bruce
T. 519-376-2121 x 2584
F. 519-378-1550

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: Email Address:

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 Ontario Health atHome?: ☐Y ☐N **Please Specify and Indicate Name Contact Number(s):**

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

St JOSEPH's HEALTH CARE LONDON

HPHA HURON PERTH HEALTHCARE ALLIANCE

Brightshores Health System