POST STROKE TRANSITIONAL CARE
APPLICATION FOR SERVICE

Tel: 705-746-5102 ext246 Fax: 705-746-8139 Mail: 27 Forest Street, Parry Sound, ON, P2A 2R2

Email: Ruthann Clark, Stroke Community Navigator at rclark@thefriends.on.ca

Date: _____

DAY MONTH YEAR

Name: _____

Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female

Date of Stroke: _____ Health Card No. _____

Address: _____

Phone: _____ Email: _____

Language: Written Communication: _____ Verbal Communication: _____

Physician / Nurse Practitioner: _____ Phone: _____

Address: _____

_____

Contact Person: ☐ SDM ☐POA _____ Relationship: _____

Name: _____ Phone: _____

_____

Referral Source: (If other than above)

Agency: _____ Title: _____

Name: _____ Phone: _____

Email: _____ Fax: _____

REASON FOR REFERRAL:

PROGRAMS:

☐ Navigation to Community
☐ Physical Activities
☐ TIME™ / FAME™
☐Aqua Therapy
☐ Cognitive Rehabilitation
☐ Living with Stroke™
☐ Monthly Stroke Support Group
☐ Healthy for You Cooking Group
☐ Functional Assessment
☐ Transitional Apartment
☐ Supportive Housing
☐ Outreach Attendant Care

SPECIAL CONSIDERATIONS: (Communication, Mobility, Vision, Transportation, Mood/Behavioural)

Reports Attached: (OT/PT/SLP/SW/OTHER) ☐ YES ☐ NO