ST. JOSEPH'S HEALTH CENTRE GUELPH

Phone: **519-767-3414**
Fax: 519-767-4160

OUTPATIENT REHABILITATION SERVICES REFERRAL FORM

Send by **Fax** to **519-767-4160** or by **mail** to: Outpatient Rehab, 100 Westmount Road, Guelph, ON N1H 5H8

Patient Eligibility Criteria:

Clients must be referred by a physician or nurse practitioner based on findings of an assessment that physiotherapy services are required. Hold a valid Health card number**,** medically stable**,** motivated to participate**,** demonstrate sufficient cognitive skills to participate in goal setting and able to integrate new learning into daily life, no acute psychiatric issues limiting the patient's ability to safely participate in the program.

Additionally the client must meet one of the following categories:

- ✓ 65 years and older
- ✓ Youth (0-19 years of age)
- ✓ Patients requiring physiotherapy services for an acute condition post hospitalization within an Acute Care or Inpatient Rehab Hospital and referred by a staff physician upon a patient's discharge from the hospital
- ✓ Post Surgery with reduced physical function and mobility
- ✓ Post Fractures / Dislocations
- ✓ High Falls Risks
- ✓ Physician or Nurse Practitioner referral for clients in receipt of Ontario Disability Support Program (ODSP) or Ontario Works benefits

Client Name: ____________________ Home Phone: ____________________

Date of Birth: ____________________ (dd/mm/yyyy) Cell Phone: ____________________

Address: ____________________ Work Phone: ____________________

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____________________ Alternate Contact: ____________________

Health card #: ____________________ Relationship to Alt. Contact: ____________________

Referring Diagnosis: ____________________

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Surgery date: ____________________ **Hospital Discharge Date:** ____________________

Physiotherapy		Occupational Therapy
☐ Musculoskeletal	☐ Falls	☐ Neuro/CVA
☐ COPD Rehab	☐ Amputee	☐ Hands/splinting
☐ Neuro/CVA	☐ SJHCG referral	

Please check to indicate which of the following services have been initiated:

☐ CCAC :__ PT, __OT, __, SLP, __ PSW	☐ Lifeline
☐ Stroke Recovery Association	☐ Vision Screening
☐ Community Programs _______________	☐ Neuropsychological Assessment
☐ Guelph Mobility/Transportation services	☐ Growing Great Kids

Referring Physician/Nurse Practitioner: ____________________

Phone: ____________________ Fax: ____________________

Family Physician: ____________________

Phone: ____________________ Fax: ____________________