Fraser Health Outpatient Rehabilitation Referral Form

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****MUST COMPLETE THIS PAGE IN FULL****

Referrals will be screened for appropriateness for Outpatient Rehabilitation.

CLIENT INFORMATION		
Client Name:	DOB:	PHN:
Address: (#, street, city, postal code)		Interpreter needed for appt? ❑ Yes ❑ No Primary Language:
Identify any barriers to the patient participating in outpatient therapy: (e.g. aggressive behaviour)	Primary Contact: (name, phone, email, relation to client)	
Mode of Transport to OP Clinic: ❑ Private ❑ HandyDart ❑ Other_____	Is this work or motor vehicle accident related? ❑ Yes ❑ No (ICBC/WCB cases are NOT accepted)	
REFERRER INFORMATION		
Referring Healthcare Professional:	Referrer Designation:	Referring Site/Hospital Unit:
Referrer Phone:	Referrer Fax:	

MEDICAL STATUS	
Primary diagnosis: (must include relevant consults/notes from Physicians, Specialists, and Allied Health)	Date of event/diagnosis: Estimated Day of Discharge:
Relevant past medical history:	

****INDICATE THE SERVICE(S) REQUIRED. ONLY COMPLETE THE APPROPRIATE SECTIONS BELOW:****

- ❑ PHYSIATRY – Client's physician or NP *aware and in agreement that patient may be seen by on-site Physiatrist (if available) at request of therapy team*.

❑ PT REFERRAL – ADULT

Please refer to the "Outpatient Rehabilitation Candidacy Guidelines" document for targeted and excluded populations.

	FUNCTIONAL BASELINE	CURRENT FUNCTION
Transfers:		
Ambulation: • WB status • Level of assist • Gait aid used • Distance		
Stairs:		
Arm function:		
Number of falls in the past year:		
PHYSIOTHERAPY GOALS		
1. 2. 3.		
Precautions/restrictions:		

If this is a referral for Lymphedema management, please indicate the following:

- ❑ Upper Extremity
  (Acute or New Exacerbation following breast surgery only)
- ❑ Lower Extremity – only available at Abbotsford Regional Hospital
  (Must include results of recent Ultrasound and ABI (Ankle-Brachial Pressure Index) with referral to rule out arterial insufficiency. Only recent lymphedema within 1 year onset.)

❑ PT REFERRAL – PEDIATRICS (for clients ages <17 years old, requiring PT only)

Please refer to the "Outpatient Rehabilitation Candidacy Guidelines" document for targeted and excluded populations.

Reason for referral:

(Note: for post-surgical referrals, include weight bear status, transfer, ambulation, etc)

_____

_____

_____

_____

❑ OT REFERRAL

Please refer to the "Outpatient Rehabilitation Candidacy Guidelines" document for targeted and excluded populations.

Power mobility assessments and home assessments are NOT provided in OP Occupational Therapy.

	FUNCTIONAL BASELINE	CURRENT FUNCTION
Cognition & Memory: (include any cognitive test scores, e.g. MoCA, MMSE)		
ADLs, IADLs:		
Hand function & Dexterity:		
OCCUPATIONAL THERAPY GOALS		
1. 2. 3.		
Precautions/restrictions:		

❑ SLP REFERRAL – COMMUNICATION

Please refer to the "Outpatient Rehabilitation Candidacy Guidelines" document for targeted and excluded populations.

- ☐ Speech
- ☐ Expressive aphasia
- ☐ Receptive aphasia
- ☐ Voice training related to a medical condition (*must include ENT report*).

COMMUNICATION GOALS
1. 2. 3.
Precautions/restrictions:

❑ SLP REFERRAL - SWALLOWING

Primary Physician: _____ Phone: _____ Fax: _____

(Include any gastroenterology reports, respirology reports, ENT reports. Must include signed Medical Imaging Requisition for Modified Barium Swallow.)

- Describe the symptoms of swallowing difficulties: _____

  _____
- What is the patient's current diet/fluid texture? _____
- Has the patient had any respiratory infections in the past year? ❑ Yes ❑ No
- Has the patient had any unintentional weight loss in the past year? ❑ Yes ❑ No

  If so, how much? _____
- Has the patient seen or been referred to a registered dietitian? ❑ Yes ❑ No

❑ OTHER CONCERNS:

_____

_____