Perth and Smiths Falls District Hospital

Day Hospital, GWM Site
(613) 267-1500, Ext. 2127
Fax: (613) 267-7618

Day Hospital – Rehabilitation Referral

Patient Name: **Date of Birth:**

Address:

Telephone # **Hospital Z Number**

Healthcard Number **Version Code:**

Diagnosis and Date

Medical History

Current Medications and Dosages:

Specific Concerns:

Program Requested: ☐ Physiotherapy ☐ Speech/Language Therapy ☐ Occupational Therapy

Please complete this section if patient is being referred to Day Hospital post discharge from Acute Stroke Unit

Investigations:

Berg Score: **MOCA Score:**

AlphaFIM®

Other (specify)

Assessed as Fit to Drive? ☐ Yes ; Approved by: _____(Physician Name)

☐ No; Further assessment required _____

Referring Physician: _____ **(please print)**

Signature: _____ **Date:** _____

PLEASE FAX applicable notes, investigations with completed form to 613-267-7618

For internal use only.
Referral Received on: _____ *Patient contacted on:* _____

Appointment Date/Time: _____ *Confirmed:* _____

Issue Date: 2020-09-28