Community Based Rehabilitation Referral

(For Rehab Office Use Only)
PRIORITY STATUS: _____
Health Record #: _____
Date Ref. Received: _____
Phone Screen Date: _____
☐ Call #1_____
☐ Call #2_____
☐ Call #3_____
Date Contact Letter Sent: _____
Appointment date: _____

Name: _____**DOB:** _____
Address: _____ **Postal Code:** _____
Phone: _____ **PHIN #:** _____ **MB Health:** _____
Contact Person (Relationship): _____ **Phone:** _____
Family Physician: _____**Clinic:**_____ **Phone:**_____**Fax:**_____

DIAGNOSIS: _____
Other Health Conditions Important to Therapy: (attach sheet with additional comments):_____
_____
Has client recently been hospitalized? ☐ No ☐ Yes reason: _____
Has client recently been seen by OT/PT? ☐ No ☐ Yes (attach report)

Community Based Rehabilitation is intended for clients whose needs are best met in their home.

Referral To:	**Reason for Referral: (Check all appropriate boxes)** **Information will assist in prioritizing referrals**		
☐ **Physiotherapy**	☐ Post-surgical rehab Fall risk (attach *FRAT) ☐ high ☐ med ☐ low	☐ Recent fracture or dislocation ☐ Recent CVA ☐ Mobility/Transfer Concerns	☐ Recent soft tissue injury ☐ Chronic Pain ☐ Other: comment below
☐ **Occupational Therapy**	☐ Post-surgical rehab Fall risk (attach *FRAT) ☐ high ☐ med ☐ low	☐ High risk pressure injury ☐ Wheelchair/Seating ☐ Mobility/Transfer concerns ☐ Activities of Daily Living	☐ Change in cognitive status ☐ Home Access Issues ☐ Recent CVA ☐ Other: comment below
COMMENTS/CONCERNS (attach sheet with additional comments):			

Home Care Services:
Case Coordinator: _____Office:_____
Phone: _____ Fax: _____Safe Visit Plan in Place: ☐ Yes (report attached) ☐
*FRAT: ☐ (report attached) Falls Risk Assessment Tool

Referral Source: (Please print) Date: _____
Name: _____Signature:_____
Phone: _____Fax:_____Address:_____

Please fax referral to Rehabilitation Services at one of the following sites based on client's community:

Boundary Trails Health Centre Fax: 204-331-8913	Portage District General Hospital Fax: 204-857-5259	Bethesda Regional Health Centre Fax: 204-320-4176

Funding information on page 2, please complete.

Funding Information

EIA Number: _____Treaty Number: _____

EIA Case Manager: _____ Phone: _____

Substitute Decision Maker: _____Phone: _____

Community Residence Manager: _____Phone: _____

Community Service Worker: _____Phone: _____

Day Program: _____Phone: _____

EXCHANGE OF INFORMATION:

Under Section 22(2)(a) of the Personal health Information Act (PHIA) (legislation in the province of Manitoba), referring agencies and other services may exchange information for the purpose of assessment, treatment, further referral and evaluation.

I understand that information will be exchanged with the 3rd parties specified below for the purposes of assessment, planning, and programming that will benefit me. The information may be shared verbally or through written reports.

Name of Resource or Service	Name, Address & Telephone # (all information required)	Release Report to
Home Care		☐
Family Doctor		☐
SH-SS Rehab Services		☐
Department of Families		☐
DHSU		☐
Jordan's Principle		☐
NIHB		☐
Vocational Program		☐
Residential Program		☐

Any other person(s) not authorized under the Act who wishes to receive information or a copy of a report, are required to obtain written consent from the individual or their authorized legal representatives.

In the process of obtaining/gathering information, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on this list.

Valid for the duration of program participation. Individual or legal guardian may request changes at any time.

_____ Date:_____

Signature of patient or legal Guardian

_____ Date:_____

Signature of witness

Review Date:						New form dated:	
Initial:							

Exchange of information – Consent to be reviewed minimum of yearly or upon each review appointment, where client is not seen regularly.