REHABILITATION SERVICES INPATIENT REFERRAL

Address:_____

Phone:_____ Cell Phone:_____ Room Number:_____

***DIAGNOSIS*:**_____

***WEIGHT BEARING STATUS*:**_____

DATE OF ADMISSION:_____DATE OF SURGERY / INJURY:_____

ACTIVITY RESTRICTIONS:_____

RELEVANT MEDICAL INFORMATION (PLEASE INCLUDE TREATMENT RECOMMENDATIONS OR ANY CONTRA-INDICATIONS):

REFERRAL TO:	**Information required to assist in prioritizing referrals for Rehabilitation Services. (Check all appropriate boxes)**	
☐ **Physiotherapy**	☐ **Occupational Therapy**	☐ **Speech-Language Pathology**
☐ CVA Date: _____ ☐ Post Surgery Date:_____ ☐ Mobility/transfer assessment ☐ Exercise program ☐ Mobility equipment assessment/ equipment needs (walker, cane etc.) ☐ Assess for eligibility for Rehab Unit ☐ Family/staff training with equipment/ transfers ☐ ACS (Bethesda only) ☐ Other (please specify):	☐ CVA Date: _____ ☐ Post surgery Date:_____ ☐ Skin integrity/pressure management risks ☐ Functional assessment ☐ Difficulty with self care ☐ ADL equipment assessment ☐ Change in cognitive status ☐ Wheelchair seating due to physical decline ☐ Home accessibility or environmental concerns ☐ Assess for eligibility for Rehab Unit ☐ High falls risk as indicated by "Falls Risk Assessment and Interventions for Inpatients" tool ☐ Awaiting placement and requires wheelchair/seating ☐ Other (please specify):	☐ CVA Date:_____ ☐ Swallowing concerns: o Coughing or throat clearing before/during/after meal o Emesis or regurgitation as a result of eating o Difficulty/unable to swallow medication, food or fluids o Difficulty chewing/food remaining in mouth ☐ Suspected aspiration pneumonia ☐ Chronic chest infections ☐ Speech and Language concerns: o Slurred speech/difficult to understand o Difficulty finding words or formulating sentences o Cannot follow directions/understand o Non-verbal ☐ Other (please specify):

- Regional Acute Care Sites to place original referral in the designated ward location
- Non-Regional Acute Care Sites 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: **204-346-9920**

Referral Source Signature: _____

Physician's Name: (print)_____ **Date**:_____

Date Referral Received by Occupational Therapist:_____ ☐ Priority 1 ☐ Priority 2
Date Referral Received by Physiotherapist:_____ ☐ Priority 1 ☐ Priority 2
Date Referral Received by Speech-Language Pathologist: ☐ Priority 1 ☐ Priority 2