



**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)		
<input type="checkbox"/> <b>Physiotherapy</b> <input type="checkbox"/> CVA Date: _____ <input type="checkbox"/> Post Surgery Date: _____ <input type="checkbox"/> Mobility/transfer assessment <input type="checkbox"/> Exercise program <input type="checkbox"/> Mobility equipment assessment/ equipment needs (walker, cane etc.) <input type="checkbox"/> Assess for eligibility for Rehab Unit <input type="checkbox"/> Family/staff training with equipment/ transfers <input type="checkbox"/> High falls risk as indicated by "Falls Risk Assessment and Interventions for Inpatients" tool <input type="checkbox"/> ACS (Bethesda only) <input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> <b>Occupational Therapy</b> <input type="checkbox"/> CVA Date: _____ <input type="checkbox"/> Post surgery Date: _____ <input type="checkbox"/> Skin integrity/pressure management risks <input type="checkbox"/> Functional assessment <input type="checkbox"/> Difficulty with self care <input type="checkbox"/> ADL equipment assessment <input type="checkbox"/> Change in cognitive status <input type="checkbox"/> Wheelchair seating due to physical decline <input type="checkbox"/> Home accessibility or environmental concerns <input type="checkbox"/> Assess for eligibility for Rehab Unit <input type="checkbox"/> High falls risk as indicated by "Falls Risk Assessment and Interventions for Inpatients" tool <input type="checkbox"/> Awaiting placement and requires wheelchair/seating <input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> <b>Speech-Language Pathology</b> <input type="checkbox"/> CVA Date: _____ <input type="checkbox"/> Swallowing concerns: <ul style="list-style-type: none"> <li><input type="checkbox"/> Coughing or throat clearing before/during/after meal</li> <li><input type="checkbox"/> Emesis or regurgitation as a result of eating</li> <li><input type="checkbox"/> Difficulty/unable to swallow medication, food or fluids</li> <li><input type="checkbox"/> Difficulty chewing/food remaining in mouth</li> </ul> <input type="checkbox"/> Suspected aspiration pneumonia <input type="checkbox"/> Chronic chest infections <input type="checkbox"/> Speech and Language concerns: <ul style="list-style-type: none"> <li><input type="checkbox"/> Slurred speech/difficult to understand</li> <li><input type="checkbox"/> Difficulty finding words or formulating sentences</li> <li><input type="checkbox"/> Cannot follow directions/understand Non-verbal</li> </ul> <input type="checkbox"/> 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**

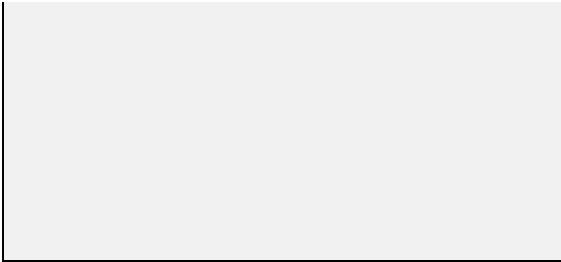
Portage District General Hospital  
Fax: **204-857-5259**

Bethesda Regional Health Centre  
Fax: **204-346-9920**

**Referral Source Signature:** \_\_\_\_\_

**Physician's Name:** (print) \_\_\_\_\_ **Date:** \_\_\_\_\_

Date Referral Received by Occupational Therapist: _____	<input type="checkbox"/> Priority 1	<input type="checkbox"/> Priority 2
Date Referral Received by Physiotherapist: _____	<input type="checkbox"/> Priority 1	<input type="checkbox"/> Priority 2
Date Referral Received by Speech-Language Pathologist: _____	<input type="checkbox"/> Priority 1	<input type="checkbox"/> Priority 2



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