REGIONAL CENTRE INPATIENT REHABILITATION UNIT REFERRAL

Bethesda Regional Health Centre ☐
Phone: 204-326-6411ext 2062
Fax: 204-346-9470

Boundary Trails Health Centre ☐
Phone: 204-331-8943
Fax: 204-331-8816

Portage District General Hospital ☐
Phone: 204-239-2265
Fax: 204-857-8437

Patient Name:	DOB:	Age:	Weight:	Height:
MHSC:	PHIN:			
Patient's Home Address:				
Next of Kin:	Relationship:		Phone:	
Referring Physician:			Phone:	
Primary Care Provider:			Phone:	
Referring Site:	Fax No.:		Phone:	

Medical Diagnosis/Surgical History:

Eligibility criteria: Is the patient:

1. Medically stable? ☐Yes ☐ No
2. Willing to actively participate in their rehab plan? ☐Yes ☐ No
3. Able to tolerate active involvement with the rehab team? ☐Yes ☐ No
4. Able to follow commands/cues? ☐Yes ☐ No
5. Expected to show improvement in functional status? ☐Yes ☐ No

Present Clinical Condition: Is the patient:

1. Requiring isolation precautions? ☐Yes ☐ No _____
2. Requiring O2 supplementation? ☐Yes ☐ No _____
3. Requiring bariatric equipment? ☐Yes ☐ No _____
4. Other: (IV therapy, tube feeds, etc.) Specify_____

Weight Bearing (WB) order: ☐WB as tolerated ☐Partial ☐Feather ☐Non WB Specify timeline:_____
Transfer Status: ☐Independent ☐ 1 Assist ☐ 2 Assist ☐ Sit/stand lift ☐ Mechanical lift
Ambulatory Status: ☐Independent ☐ 1 Assist ☐ 2 Assist ☐ Mobility Aids-Specify_____

Has the patient been recommended for rehab by: ☐ OT ☐ PT ☐ SLP

Please include the following documentation: (All required if relevant)

☐ Recent OT, PT, SLP report/progress notes
☐ Operative Report
☐ Recent lab/diagnostic reports
☐ Medication list/allergies
☐ Medical History & Discharge Summary
☐ Cognitive Status (MMSE, MoCA)
☐ Previous Home Care/Home Care Plan
☐ PCH Application made ☐Yes ☐No Date:_____

Referral Completed by: _____Phone #:_____Date:_____

Referral Received by:_____Date:_____