REHABILITATION SERVICES OUTPATIENT REFERRAL FORM

(For Rehab Office Use Only)
PRIORITY STATUS:_____
Health Record #:_____
Date referral received:_____
Date notification letter sent:_____
☐ Call #1_____
☐ Call #2_____
☐ Call #3_____
Date contact letter sent_____
Appointment date:

Name:_____
Mailing Address:_____
Postal Code:_____ **D.O.B:** DD / MMM / YYYY
MB Health #:_____ **PHIN:**_____
Phone:_____ **Cell #:**_____ **Work/Message:**_____
Family Physician:_____ **Clinic**:_____

DIAGNOSIS _____

DATE OF SURGERY / INJURY _____

HAND SURGERY DETAILS INCLUDING TENDON ZONE/INTEGRITY:_____

RELEVANT MEDICAL INFORMATION (INCLUDE **CONTRA-INDICATIONS):**

THIRD PARTY COVERAGE: ☐ NO ☐YES: ☐WCB ☐MPI ☐ OTHER _____

REFERRAL TO:	**Information required to assist in prioritizing referrals for Rehabilitation Services. (Check all appropriate boxes)**		
☐ **Physiotherapy**	☐ **Occupational Therapy**	☐ **Speech-Language Pathology**	☐ **Audiology**
☐ Acute hand injury ☐ Recent CVA Date:_____ ☐ Post surgical rehab ☐ Recent fracture or dislocation ☐ Recent D/C from hospital ☐ Recent soft tissue injury ☐ Recent inability to work/function ☐ Mobility/balance Concerns ☐ Vestibular rehab ☐ Pre-op rehab ☐ Chronic pain	☐ Acute hand injury ☐ Recent CVA Date:_____ ☐ High risk skin breakdown ☐ Recent D/C from hospital ☐ Cognitive concerns ☐ Joint protection ☐ Recent inability to work/ function ☐ Wheelchair assessment ☐ No other form of mobility ☐ Wheelchair reassessment	☐ Swallowing concerns (***Diagnostic Imaging - Videofluoroscopic Swallow Study (VFSS) request attached for any swallow referral***) ☐ Recent CVA Date:_____ ☐ Difficulty understanding information ☐ Unable to communicate verbally ☐ Speech unclear or slurred ☐ Word finding difficulty ☐ Cognitive communication assessment ☐ Requires assistive communication device assessment ☐ Voice problems *(ENT examination results must accompany referral)* ☐ Stuttering/fluency	☐ Hearing difficulty ☐ Unilateral/Asymmetrical loss ☐ Tinnitus began _____ ☐ 1 ear ☐ both ears ☐ Vertigo/Dizziness Date of onset:_____ ☐ Pre-Op ☐ Post-Op ☐ Middle ear infection ☐ Audiogram ☐ Sudden onset hearing loss Date: _____ ☐ Second opinion required ☐ Recent head/ear trauma Date and how: _____ ☐ History of noise exposure ☐ Ototoxic medication ☐ Bacterial meningitis ☐ Previous hearing test

Referral Source Signature:_____
Referral Source Print:_____
Address:_____
Phone:_____ **Fax:**_____
Date of next medical reassessment:_____
Date of referral:_____

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

☐ **Boundary Trails Health Centre** **Fax: 204-331-8913**

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

For Rehab Services Use Only Cross referral from: ☐Audiology ☐OT ☐PT ☐SLP