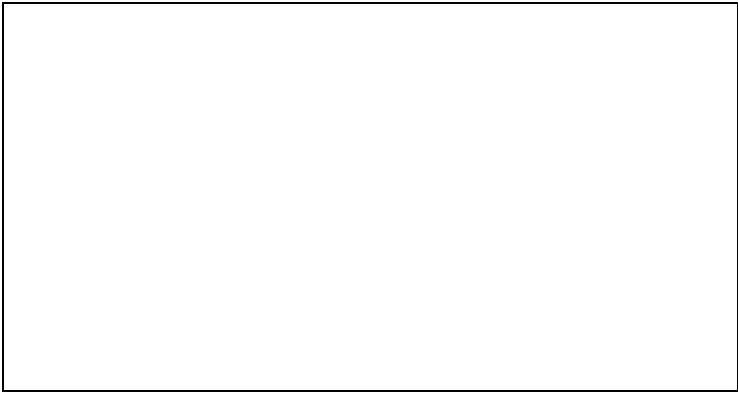




REHABILITATION SERVICES
Personal Care Home
Referral Form



REFERRAL TO: Information required to assist in prioritizing referrals for Rehabilitation Services.
 (Check all appropriate boxes)

<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Speech-Language Pathology	<input type="checkbox"/> Physiotherapy
<input type="checkbox"/> High risk of falls related to mobility, transfers and/or environmental issues. <input type="checkbox"/> High risk of skin breakdown or existing skin breakdown related to immobility and/or positioning as indicated by a recent Braden Scale for Predicting Pressure Sore Risk. <input type="checkbox"/> Wheelchair/Seating assessment with identified safety concerns. <input type="checkbox"/> Wheelchair assessment- no other form of safe mobility <ul style="list-style-type: none"> o Choosing a Wheelchair for Use in The PCH document has been provided to family – CLI.6310.PR.001.SD.01 <input type="checkbox"/> Mobility assessment with no immediate risk factors for falls, skin breakdown, or safe mobility including wheelchair or transfer assessment <input type="checkbox"/> Other OT related requests - Specify below in “Describe information relevant to the referral.”	<input type="checkbox"/> Swallowing concerns as indicated by a recent TTMD-R screen. (copy of the completed TTMD-R must be included with the referral) <input type="checkbox"/> Swallowing concerns related to a recent acute event or progressive condition i.e. CVA <input type="checkbox"/> Diet upgrade <input type="checkbox"/> Communication needs - Specify below in “Describe information relevant to the referral.”	<input type="checkbox"/> Recent acute event requiring rehab follow up related to transfers, mobility and exercise programs. <input type="checkbox"/> Mobility/mobility aids assessment with identified safety concerns <input type="checkbox"/> Other - Specify below in “Describe information relevant to the referral.”

Describe information relevant to the referral.

- Bethesda Regional Health Centre
OT/PT Fax: 204-320-4176
SLP Fax: 204-346-9920
- Boundary Trails Health Centre
Fax: 204-331-8913
- Portage District General Hospital
Fax: 204-857-5259

Referred by: _____ **Date:** _____

- Assessment process information shared
- Verbal consent for OT PT SLP Assessment obtained

From: _____ **By:** _____
 (Resident’s ADM) (Print and signature)

Date: _____