REHABILITATION SERVICES
Personal Care Home
Referral Form

REFERRAL TO:	Information required to assist in prioritizing referrals for Rehabilitation Services. (Check all appropriate boxes)	
☐ **Occupational Therapy**	☐ **Speech-Language Pathology**	☐ **Physiotherapy**
☐ High risk of falls related to mobility, transfers and/or environmental issues. ☐ 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. ☐ Wheelchair/Seating assessment with identified safety concerns. ☐ Wheelchair assessment- no other form of safe mobility o Choosing a Wheelchair for Use in The PCH document has been provided to family – CLI.6310.PR.001.SD.01 ☐ Mobility assessment with no immediate risk factors for falls, skin breakdown, or safe mobility including wheelchair or transfer assessment ☐ Other OT related requests - Specify below in **"Describe information relevant to the referral."**	☐ Swallowing concerns as indicated by a recent TTMD-R screen. **(copy of the completed TTMD-R must be included with the referral)** ☐ Swallowing concerns related to a recent acute event or progressive condition i.e. CVA ☐ Diet upgrade ☐ Communication needs - Specify below in **"Describe information relevant to the referral."**	☐ Recent acute event requiring rehab follow up related to transfers, mobility and exercise programs. ☐ Mobility/mobility aids assessment with identified safety concerns ☐ Other - Specify below in **"Describe information relevant to the referral."**

Describe information relevant to the referral.

Referred by: _____ **Date:** _____

☐ Assessment process information shared

☐ Verbal consent for ☐ OT ☐ PT ☐ SLP Assessment obtained

From:_____**By:**_____

(Resident's ADM) **(**Print and signature)

Date:_____

☐ **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