COMMUNITY **Stroke Rehabilitation** TEAM

**Office Use Only:**

**Date Referral Received:**_____

**ID#:** _____

# Referral Form


**CENTRAL INTAKE OFFICE**
Parkwood Institute – Main Building
P.O. Box 5777, STN B, London, ON
Telephone: (519) 685-4292 ext. 45034
Toll Free: 1-866-310-7577
Fax: (519) 685-4802


**Please indicate the county you are referring for:**

Oxford □ Middlesex □ S/W Norfolk □ Elgin □ Huron □
Perth □ Grey □ Bruce □

## Client Information:

| | | |
|---|---|---|
| Name: | Health Card #: | Registration #: |
| Address: | City/Town: | Postal Code: |
| Phone: | Date of Birth (yy/mm/dd): | Sex: □M □F |

Marital Status: □ Single □ Married □ Divorced □ Separated □ Common-law □ Widow(er)

Work Status: □ retired □ working □ other

Preferred Language: □ English □ French □ Other (please indicate):

| | | |
|---|---|---|
| Next of Kin: | Telephone: | Relationship: |

Alternate Contact Information: (Who should we make first contact with if **not** the client?) :

## Current Status:

Has the client been informed and consents to referral? □ Yes □ No

| | |
|---|---|
| Is client currently in hospital? □ Yes □ No | Facility: |
| Admission to Hospital (yy/mm/dd): | Admission FIM (if available): |
| Expected Date of Discharge (yy/mm/dd): | Discharge FIM (if available): |

Have you attached any relevant reports/discharge summaries? □ Y □ N □ will forward later

Expected Discharge Destination: □ Home □ LTC □ Other (If other please describe):

Status of Driver's License: □ valid □ suspended □ letter sent to MTO by physician □ unknown

## Physician Information:

| | |
|---|---|
| Attending Physician Name: | Phone: |
| Family Physician Name: | Phone: |

Physician Signature (optional):

## History:

| Date of stroke: (yy/mm/dd) | Type of stroke (if known or for assistance, please ask your health care provider): | Diet: Does client follow a special diet? ☐Y ☐N |
|---|---|---|
| | ☐ Ischaemic (clot)<br>☐ Hemorrhagic (bleed)<br>☐ Not known | ☐ Weight Loss/Gain<br>☐ Diabetic<br>☐ Modified Texture (i.e., pureed, minced, thick fluids)<br>☐ Other: |

**Presenting Difficulties (What areas are you having difficulty with? Please check all that apply.):**

- ☐ difficulty with arm and hand function
- ☐ difficulty with walking and getting around
- ☐ difficulty with vision and perception
- ☐ talking and understanding
- ☐ taking care of myself
- ☐ support to care for my loved one
- ☐ concerned about my finances
- ☐ learn more about community resources
- ☐ eating well and preparing meals
- ☐ household tasks
- ☐ difficulty swallowing
- ☐ safety in the home
- ☐ adjusting to life after stroke
- ☐ managing emotional changes
- ☐ learn more about my stroke
- ☐ learn to reduce risk of another stroke
- ☐ impulsiveness
- ☐ fatigue
- ☐ difficulty with memory
- ☐ boredom
- ☐ learn ways to improve my quality of life
- ☐ other: _____

**Priorities for service:** **(in the client's own words where possible)**

Based on the difficulties listed above, I want to improve in these top 3 areas (rehab goals):

1.

2.

3.

Is there anything else you think we should be aware of?

**Relevant Medical/Psychiatric History** (MRSA, Alzheimer's, Parkinson's, Dementia…) Attach Medication List if available:

Reaction to Medication ☐Y ☐N:
If yes please describe:

Latex or Environmental Reaction ☐Y ☐N:

**Is there a history of:** ☐ Substance use ☐ Criminal offences or charges
please describe:

## Referral Information:

| Date of referral : (yy/mm/dd) | **Referral Source:** (Name of Person filling out the form - indicate agency if applicable) |
|---|---|

**Currently involved with SW LHIN?:** ☐Y ☐N **Please Specify and Indicate Name Contact Number(s):**

**Other agencies/services?** (i.e., adult day programs, privately paid therapies, transportation services….):

**Email Address: communitystrokerehab@sjhc.london.on.ca**