

Brant Community Healthcare System

Outpatient Rehabilitation

Amputee Program

Phone: (519) 751-5523

Fax : (519) 751- 5859

Services Required: ☐ PT

☐ P & O

Patient Information

Name:

Address:

Postal Code:

Phone:

Date of Birth:

dd/mm/yyyy

Sex: ☐ M

☐ F

Alternate Patient Contact Name:

Relationship to Patient:

Phone:

Current Status

Has the patient consented to this referral??

☐ Yes

☐ No

Condition:

☐ Above Knee Amputation

☐ Below Knee Amputation

☐ Left

☐ Right

Date of surgery: _____
dd / mm / yyyy

Name of Surgeon: _____

Is the patient currently in hospital?

☐ Yes

☐ No

Facility: _____

Admission date: _____
dd / mm / yyyy

Date of discharge: _____
dd / mm / yyyy

Relevant Medical History (Dementia, Hypertension, Depression, etc)

Are there any medical precautions/contraindications for participating in therapy?

☐ No

☐ Yes

Explain: _____

Is there any other information you feel we should be aware of?

Physician Information

Attending Physician Name: _____

Date: _____

Family Physician Name: _____

Physician Signature: _____

Revised 31/07/14