Brant Community Healthcare System
Outpatient Neurological Rehabilitation Program
Phone:(519)751-5523
Fax: (519)751-5859

Services Required (Please circle) **PT** **OT** **RN** **SLP**

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

Referral Source: Date:

Condition:

☐ Stroke ☐ Brain Injury ☐ Other: _____

Detail of Diagnosis: _____

Date of Onset: _____ dd / mm /yyyy

Is the patient currently in hospital? ☐ Yes Facility: _____ ☐ No

Admission date: _____ dd / mm/ yyyy | Expected date of discharge: _____ dd / mm / yyyy

Relevant Medical History/ Medical Precautions/Contraindications for participating in therapy?

☐ No ☐ Yes Explain: _____

Patient Driving Information

Medically fit to drive: ☐ Yes ☐ No

Has the Ministry of Transportation been notified of the patients medical condition?

☐ Yes ☐ No

Priorities for service:

My goals for rehabilitation are:

What areas are you having difficulty with? Please check all that apply:

☐ Arm & hand function	☐ Walking/leg function
☐ Fatigue/ Endurance	☐ Vision and perception
☐ Bathing/ dressing	☐ Concentration/Memory
☐ Safety in the home	☐ Participation in leisure
☐ Swallowing	☐ Knowledge about my diagnosis/illness
☐ Speaking/Understanding	☐ Return to work

Physician Information

Attending Physician Name: Phone:

Family Physician Name: Phone:

Physician Signature:

Revised 31/07/14