HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

SERVICES DE SOUTIEN À DOMICILE ET EN MILIEU COMMUNAUTAIRE
Champlain

Bruyère

Outpatient & Community Stroke Rehabilitation Programs

Referral Form

Complete and fax to **613-745-8243**

If patient requires **only** a physiatry consult, please use a standard medical consultation form instead.

Patient consents to referral	☐Yes			☐No		
Patient Name			**HCN**		**VC**	
Date of Birth		**Home Address**			**Apt/Unit**	
City / Town				**Postal Code**		
Phone			**Primary Care Provider**			
Patient prefers	☐EN	☐FR	☐Other (specify)			
Contact person to complete intake screen, if different than patient						
Relationship to patient				**Phone**		
Consent to speak with above person by phone	☐Yes			☐No		
Date of stroke		**Location of stroke**				
Type of stroke	☐Ischemic		☐Hemorrhagic		☐Unable to determine	
Impairment	☐Left / Right body		☐Left body	☐Right body	☐No paresis	
Hospital Discharge Date		**Expected Discharge Destination**				
		☐Home	☐Retirement Home	☐Other (specify address)		
Discharge address (if different from home):						

Infection control						
☐None	☐MRSA	☐VRE	☐CDIFF	☐ESBL	☐TB	☐Other (specify)

Driving		
Does patient have a valid driver's license?	☐Yes ☐ No	
Ministry of Transportation notified	☐**Yes**: by ☐ Physician or ☐ OT	☐**No**: Has pt been advised not to drive? ☐Yes ☐ No
MD who advised patient not to drive		
Follow up planned		
Para Transpo Application complete	☐Yes ☐ No	

☐ **Most responsible physician discharge summary attached (required)**

☐ **Allied health discharge summaries attached (if allied health involved)**

Requested Stroke Rehabilitation Discipline(s)

Discipline	Focus of Intervention
☐ **OT**	
☐ **PT**	
☐ **SLP**	
☐ **SW**	
☐ **RD**	

Request for other Home and Community Care Support Services:

☐PSS (Non-urgent) ☐OT (Urgent home safety assessment)

☐PT (Urgent home safety assessment) ☐SLP (Swallowing assessment only)

Additional comments (include precautions)

Exclusion Criteria patients who:	
☐Require mechanical-lift transfers	☐Are admitted to long-term care

Eligibility (contact Stroke Care Coordinator to discuss if needed: 613-745-5525 ext 5875)
I have verified that the patient meets the program's admission criteria:
☐Onset of stroke < six months
☐Valid OHIP card (if no OHIP card, contact the Bruyère Stroke Rehab Co-ordinator: 613-562-6262 ext 1007)
☐FIM > 80 or AFIM >80 or patient able to engage in meaningful, goal-directed activities for up to an hour
☐Able to manage toileting independently or has a support caregiver to provide assistance during rehabilitation sessions
☐If patient requires 2 persons to assist with transfers, a support caregiver must be present for sessions
☐Understands English or French. **If no**: ☐ accompanied by someone who is able to interpret during therapy
☐Patient requires physiatry consult to address stroke rehabilitation issues (if referred from acute care)

Referral completed by (Print name)			
Date		**Phone**	
Referring institution		**Most responsible physician**	