St. Joseph's HEALTH CENTRE GUELPH
Serving with Compassion, Care and Courage

Phone: 519-767-3414
Fax: 519-767-4160

OUTPATIENT REHABILITATION SERVICES REFERRAL FORM

Send by **Fax** to **519-767-4160** or by **mail** to: Outpatient Rehab, 100 Westmount Road, Guelph, ON N1H 5H8

Patient Eligibility Criteria:

Clients must be referred by a physician or nurse practitioner based on findings of an assessment that physiotherapy services are required. Hold a valid Health card number**,** medically stable**,** motivated to participate**,** demonstrate sufficient cognitive skills to participate in goal setting and able to integrate new learning into daily life, no acute psychiatric issues limiting the patient's ability to safely participate in the program.

Additionally the client must meet one of the following categories:

- ✓ 65 years and older
- ✓ Youth (0-19 years of age)
- ✓ Patients requiring physiotherapy services for an acute condition post hospitalization within an Acute Care or Inpatient Rehab Hospital and referred by a staff physician upon a patient's discharge from the hospital
- ✓ Post Surgery with reduced physical function and mobility
- ✓ Post Fractures / Dislocations
- ✓ High Falls Risks
- ✓ Physician or Nurse Practitioner referral for clients in receipt of Ontario Disability Support Program (ODSP) or Ontario Works benefits

Client Name: _____ Home Phone: _____

Date of Birth: _____ (dd/mm/yyyy) Cell Phone: _____

Address: _____ Work Phone: _____

_____ Alternate Contact: _____

Health card #: _____ Relationship to Alt. Contact: _____

Referring Diagnosis: _____

Surgery date: _____ **Hospital Discharge Date:** _____

Physiotherapy		Occupational Therapy
☐ Musculoskeletal	☐ Falls	☐ Neuro/CVA
☐ Neuro/CVA	☐ Amputee	☐ Hands/splinting

Please check to indicate which of the following services have been initiated:

☐ WWLHIN Home & Community Care: __ PT, __OT, __, SLP, __ PSW	☐ Lifeline
☐ Stroke Recovery Association	☐ Vision Screening
☐ Community Programs _____	☐ Neuropsychological Assessment
☐ Guelph Mobility/Transportation services	☐ Growing Great Kids

Referring Physician/Nurse Practitioner: _____

Phone: _____ Fax: _____

Family Physician: _____

Phone: _____ Fax: _____