Bluewater Health

Rehabilitation Outpatient Services
2nd floor London Building
Phone (519) 464-4400
Ext. 4416
Fax (519) 464-4446

Community Reintegration Program

Name _____

Address _____

_____

Postal Code _____

Phone _____

Primary Physician _____ Date of Birth_____ (DD/MM/YYYY) Gender: ☐Male ☐Female

Referring Physician _____ Health Card Number _____

Contact Person

Name _____ Phone _____ Relationship _____

Medical Information (Must be completed in detail. Please attach pertinent reports)

Referring Diagnosis _____

Hx of Illness:(recent hospitalizations, consultations, operations) _____

_____

Conditions affecting Health Status (COPD, Diabetes, MI, Angina, etc.) _____

_____

Mental Status (specify) _____

Reasons for Referral _____

Physicians Specific Orders _____

Client presently ☐ At Home ☐ In Hospital

If hospitalized, where? _____

Expected discharge date:_____ (DD/MM/YYYY)

Please indicate therapies required and list specific goals for each:_____

_____

☐ Physiotherapy (falls prevention, progress mobility, conditioning/reactivation)

☐ Occupational Therapy (upper extremity rehabilitation, cognitive-perceptual, assess & treat functional life skills)

☐ Speech-Language Pathology (Communication, Cognitive and/or Bedside Swallowing Assessment)

Signature of Referring Physician _____ **Date** _____ (DD/MM/YYYY)

Date Referral Received _____ (DD/MM/YYYY)

PLEASE NOTE: A referral to this program will serve as a referral to all of the services within it (PT, OT, SLP). Once referred, patients will participate in a multidisciplinary team intake process where the need for each discipline will be determined.