Toronto Orthopedic Services

REFERRAL FORM

Please fax to 416-762-4437

SECTION 1: DEMOGRAPHIC INFORMATION

PATIENT'S NAME: (Last Name, First Name)

GENDER ☐ M ☐ F

DOB _____/ _____/_____ (YYYY-MM-DD)

HOME ADDRESS _____ Apt. # _____ Postal Code _____

Alternate Telephone # _____ Home Telephone # _____ Emergency Contact # _____

HEALTH CARD NUMBER **Version** **Expiry Date** (if available)

Province/Territory issuing Health Card ☐ Ontario ☐ Other (specify):

FAMILY PHYSICIAN'S CONTACT INFORMATION ☐ No Family Physician

Name _____ Address _____

Phone _____ Fax _____

SECTION 2: REFERRAL INFORMATION

REFERRAL DATE: **(YYYY-MM-DD)**

CLIENT IS CURRENTLY:

☐ At home

☐ Other (specify):

IF CLIENT IS IN HOSPITAL, PROVIDE:

Date of Admission _____/ _____/_____ (YYYY-MM-DD)

Planned Date of Discharge _____/ _____/_____ (YYYY-MM-DD)

E-STIM SERVICE(S) REQUESTED

☐ Assessment for FES FDS ☐ Custom Orthoses ☐ Serial Casting

☐ Upper Extremity ☐ Lower Extremity

SPECIAL CONSIDERATIONS (E.G. HOUSING, TRANSPORTATION, SOCIAL SUPPORT, VISUAL IMPAIRMENT, OTHER IDENTIFIED RISKS)

IS CLIENT CURRENTLY RECEIVING OTHER REHAB SERVICES? ☐ No ☐ Yes (specify):

REPORTS ATTACHED? (e.g. CT scan, OT/PT/SLP/SW notes, etc.) ☐ Yes ☐ No

SECTION 3: REASON FOR REFERRAL

PATIENT DIAGNOSIS

☐ Stroke (CVA) ☐ Multiple Sclerosis

☐ Brain Injury ☐ Spinal Cord Injury and Level: _____

☐ Cerebral Palsy ☐ Parkinson's Disease ☐ Other:

REFERRAL FORM CONT'D	PATIENT'S NAME:

DIAGNOSIS DETAILS Date of Incident _____/_____/_____ (YYYY-MM-DD) Affected Side: R / L / Both

PATIENT GOALS / TREATMENT PLAN (Identity SMART goals – specific, measurable, attainable, realistic and timely)

MOBILITY ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

Ambulation: ☐ Independent ☐ Assistance ☐ Supervision

Mobility Aid (if required): ☐ AFO ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other:

Transfers: ☐ Independent ☐ Assistance ☐ Supervision

Activity Tolerance (specify): _____ ☐ Paresis/paralysis ☐ Falls/history of falls ☐ Other:

Goals/Comment:

COMMUNICATION ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Hearing ☐ Vision ☐ Language, comprehension ☐ Language, expression

☐ Speech Dysarthria ☐ Speech Apraxia ☐ Other:

Goals/Comment:

CONGNITIVE ISSUES IDENTIFIED? ☐ No ☐ Yes (specify below)

☐ Orientation ☐ Participation ☐ Judgment ☐ Carry-over/New Learning

☐ Memory ☐ Frustration tolerance ☐ Other:

SECTION 4: RELEVANT MEDICAL INFORMATION

PAST MEDICAL/SURGICAL HISTORY (relevant to rehab referral)

[Patients with one or more contraindication will not be a candidate for FES FDS.]

☐ Pacemaker* or defibrillator?

☐ Recent fracture or dislocation in affected leg?

☐ Pregnant or planning a pregnancy?

☐ Malignant tumour, lesion or open wound on affected leg?

* Pacemakers may be cleared by implanting cardiologist.

REFERRAL FORM CONT'D	PATIENT'S NAME:

Has or will the patient be treated with Botox? ☐ No ☐ Yes

If so, on what date: _____/ _____/_____ (YYYY-MM-DD) Major muscles injected:

[Patients with a history of seizures, baclofen pumps and metallic implants will need physician clearance prior to evaluation for FES FDS.]

Prior history of seizures? If yes, when was most recent seizure: _____/ _____/_____ (YYYY-MM-DD)

Baclofen pump? If yes, explain need:

Metallic implants? If yes, where:

FOR ABI / NEURO REFERRALS ONLY (where applicable):

Trauma: ☐ No ☐ Yes Seizures: ☐ No ☐ Yes Post-Traumatic Amnesia resolved? ☐ No ☐ Yes

Previous history of ABI? ☐ No ☐ Yes (specify):

CT/MRI Date of Completion: _____/ _____/_____ (YYYY-MM-DD) Facility:

CARDIOVASCULAR & PULMONARY HISTORY (as applicable): ☐ None known

[Patients with a Cardiovascular & Pulmonary history will need physician clearance prior to beginning regular exercise.]

Previous CVA	☐ No	☐ Yes	Myocardial Infarction	☐ No	☐ Yes
Pulmonary Disease	☐ No	☐ Yes	Heart failure	☐ No	☐ Yes
Peripheral Vascular Disease	☐ No	☐ Yes	Atrial Fibrillation/Other arrhythmias	☐ No	☐ Yes

Known Cardiac Risk Factors: ☐ Hypertension ☐ Diabetes I / II ☐ Family History ☐ Smoking ☐ Hyperlipidemia

THIS REFERRAL WAS COMPLETED BY:

Name _____ Discipline _____

Phone _____ Fax _____ Email _____

Signature _____ Date _____/ _____/_____ (YYYY-MM-DD)

Hospital + Program/Service or Organization _____

Please send me follow-up info via:

☐ Phone ☐ Fax ☐ Email ☐ N/A