Office Use Only: Date Received

COMPREHENSIVE SPASTICITY MANAGEMENT PROGRAM REFERRAL FORM
Regional Rehabilitation Centre

PATIENT DEMOGRAPHICS AND HISTORY

Patient's Name _____

Date of Birth _____

Health Card Number _____ Ver _____

Present Address _____

PERSON TO CONTACT TO MAKE FIRST APPOINTMENT

Name _____ Phone _____ Relationship _____

ARE THERE ANY TIMES THE PATIENT WILL NOT BE AVAILABLE FOR TREATMENT? _____

DIAGNOSIS RELEVANT TO THIS REFERRAL _____

Please describe any previous treatment for spasticity _____

Precautions _____

If Inpatient: Current Location _____ Expected D/C Date _____

TRANSPORTATION: What method of transportation has been planned? _____

❑ DARTS — DARTS #: _____ ❑ PRIVATE: _____ ❑ OTHER: _____

LANGUAGE: Spoken/Understood: English Other _____ Interpreter available if needed? ❑ Yes ❑ No

Name and Contact Information of Interpreter if needed _____

CURRENT MOBILITY: Inside _____ Aid _____ Outside _____ Aid _____

DESCRIBE SPECIFIC ISSUES AND TREATMENT GOALS (check all that apply)

❑ Transfers ❑ Hygiene ❑ Positioning ❑ Prevention of Skin Breakdown
❑ AFO Fit ❑ Bracing Fit ❑ Spasms ❑ Clonus ❑ Mobility

Notes: _____

REFERRAL SOURCE: Name _____ Discipline _____

LOCATION: _____ Phone # _____

REFERRING PHYSICIAN _____ **SIGNATURE** _____

PHONE _____ **FAX** _____

REFERRING PHYSICIAN BILLING NUMBER _____

PLEASE FAX COMPLETED REFERRAL FORM ALONG WITH CURRENT MEDICATION LIST AND ANY ADDITIONAL DOCUMENTATION TO 905-577-8231