PETERBOROUGH REGIONAL HEALTH CENTRE

Outpatient Stroke Program

Outpatient Rehabilitation

1 Hospital Drive Peterborough, ON K9J 7C6
t: 705-740-8351 | f: 705-876-5840

PATIENT LABEL

Please ensure that the referral is fully completed and supporting documents attached before faxing to the department.

Date of referral: _____ (DD/MM/YYYY)

Patient Name:	Date of Birth (DD/MM/YYYY):	Health Card #:

Address:	TELEPHONE Home: _____ Work: _____ Cell: _____
Diagnosis:	Date of Stroke Onset: Last Admission Date:

☐ OT: Reason for referral: ☐ Cognition/Perception ☐ Upper Extremity
☐ Other: _____

☐ PT: Reason for referral: ☐ Transfers ☐ Strength ☐ Balance ☐ Abnormal Gait ☐ Gait Aid Progression
☐ Other: _____

☐ SLP: Reason for referral: ☐ Aphasia ☐ Apraxia of Speech ☐ Dysarthria
☐ Other: _____

Health History/Precautions:

☐ Arthritis ☐ Diabetes ☐ Dyslipidemia ☐ Other:
☐ Allergies ☐ COPD/Asthma ☐ Epilepsy _____
☐ Cancer: _____ ☐ HTN ☐ Liver Disease _____

Does your patient have any pre-exsisting health conditions that would make exercising unsafe, difficult or high risk? ☐ NO ☐ YES, please note: _____

Attached are the following results:

☐ Imaging reports (MRI, CT-CTA) ☐ Stroke Discharge Notes (OT, PT, SLP, Hospitalist)
☐ Home Care Progress/Discharge Notes ☐ Resent Consultation Notes
☐ Raw Data from Cognitive/Perceptual Screens ☐ Other: _____

Practitioner's Name (please print):	Practitioner's Telephone:
I verify that the above named patient is appropriate for the Out-Patient Stroke Rehabilitation Program **Signature of Referring Practitioner:**	**Date (DD/MM/YYYY):**

FOR OFFICE USE:

K# _____ Account #_____ Initials _____