Halton Healthcare

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Oakville Trafalgar Memorial Hospital
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Phone: (905) 338-4367 Fax: (905) 815-5134

Referral for

Assess and Restore Program

Patient Identification Stamp

H.C.#

Inpts only: D/C date and name of facility _____

_____

Name: _____ D.O.B: _____ Male: ☐ Female: ☐

Tel: _____ Cell: _____ Alternate contact: _____

Referring Diagnosis: _____

Other Medical History: _____

Cardiac History: Y ☐ N ☐ If yes, list restrictions: _____

Contraindications/Complications/Precautions: _____

Other recent/ongoing treatments ie chemo/radiation therapy: _____

Treatment Goals:

PT: _____

OT: _____

SLP: _____

Duration of Symptoms: ☐ < 3 months ☐ 3-6 months ☐ > 6 months

Functional Level: ☐ severely affected ☐ slightly affected ☐ normal

Home living situation: ☐ alone ☐ with others (specify) _____

Is patient at risk for falls and/or admission to hospital? Explain: _____

Name of Therapist/referral source: _____ Tel: _____

Please provide discharge summaries/ physician reports where possible.

Physician's Signature: _____ Date: _____
(required)

Physician name (print) or stamp: _____ Tel: _____

<u>* Please note *</u>

This is a multidisciplinary program. Patients will be assessed and treated at the discretion of the therapists. Patient is responsible for arranging transportation to and from the program.