



Oakville Trafalgar Memorial Hospital
3001 Hospital Gate, Oakville, ON, L6M 0L8
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Rehabilitation Services
Referral for Outpatient
NeuroRehabilitation
Step-Up Program

ADDRESSOGRAPH / LABEL

In-Patient Only:

Date of Discharge: _____

Name of Facility: _____

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

Telephone: _____ Cell: _____

Alternate Contact - Name: _____ Telephone: _____

Referring Diagnosis: _____ Date of event: _____

Cardiac history? ☐ Yes ☐ No If Yes, list restrictions: _____

Any other on-going medical treatments?(e.g., chemotherapy /radiation): _____

Past Medical History: _____

Other contraindications/complications/precautions: _____

List referrals made to other facilities: _____

Treatment Goals:

➤ PT: _____

➤ OT: _____

➤ SLP: _____

Please provide Discharge Summaries / Physician Reports where possible

Names of Therapists: _____ Phone: _____

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

Physician's Name/Stamp: _____ Phone: _____
(print)

*** Please Note ***

- ◆ This constitutes referral to a multidisciplinary program. Patients will be assessed and treated by the appropriate discipline or disciplines within the program.
- ◆ Patient is responsible for arranging transportation to and from the program.