Brockville General Hospital

Place client identification label here if available.

Referral Form

Community Stroke Rehabilitation Program

Client Information:			
Last Name:	**First Name:**	**MRN/CR #:**	
Date of Birth: (y y / m m / d d)	**Gender:** ☐Male ☐Female ☐ Other:	**Telephone:**	
Contact person to arrange the first appointment: ☐ Client ☐ Alternate	**Alternate Contact:**	**Relationship:**	**Telephone:**

Current Status:	
Has consent ben received for this referral? ☐ Yes ☐ No	**Referral Source:** ☐ BGH ISU Acute ☐ KHSC ☐ Other:
Expected Discharge Date: (y y / m m / d d)	**Discharge Location:**
Is this client being referred to Home and Community Care Support Services? ☐ Yes ☐ No **If yes,** please specify the services (nursing, PSW, OT, equipment, etc.)	**AlphaFIM:**
Communication: ☐ Patient Speaks English ☐ Expressive Aphasia ☐ Receptive Aphasia ☐ Other communication notes, please specify:	

History:	
Stroke Onset: (y y / m m / d d)	**Stroke Type:** ☐Hemorrhagic ☐ Ischemic Other Details:

Referral Information:

Profession(s) Required: ☐ Physiotherapy (PT) ☐ Speech-Language Pathology (SLP) ☐ Occupational Therapy (OT) ☐ Social Work (SW)

Presenting Difficulties/Objectives: *(goals/reasons for referral to each discipline)*

PT: _____

OT: _____

SLP: _____

SW: _____

Referring Practitioner: *(name and title)*	**Contact:** *(email/telephone)*	**Date of Referral:** (y y / m m / d d)

Referral Checklist:

☐ *I have verified that the client meets the programs eligibility criteria.*

☐ *I have attached the most recent/relevant allied health documentation.*

** Submit completed referral by fax to BGH CSR at (613-342-1566)*

BGH CSR Office 613-345-5649 ext. 51310

IN OFFICE USE ONLY		
Date Received:	Referral Status:	Initial Visit: