Saskatchewan Health Authority

Physical Medicine and Rehabilitation
7th Floor, Saskatoon City Hospital
Phone: (306) 655-8825
Fax: (306) 655-8813

REHABILITATION DAY SERVICES REFERRAL FORM

Specialized Rehabilitation Services for:		**Admission Criteria:**	
Stroke	Spinal Cord Injury	1.	Able to tolerate/attend weekly outpatient therapy at SCH.
Amputation	Neurological Conditions	2.	Attainable therapeutic goals (please identify below).
Multiple Sclerosis		3.	Medically stable.
Brain Injury		4.	Unable to access therapy elsewhere for the same goals.
		5.	Has assistant to attend if personal care is needed.

PATIENT DEMOGRAPHICS				
NAME: (As seen on Provincial Health Card)			DATE: (DD/MMM/YYYY)	
PHN:	PROV:	BIRTHDATE: (DD/MMM/YYYY)	SEX: □ Male □ Female	
ADDRESS:	Street:			
	City:	Province:	Postal Code:	
PHONE #:	Primary:	Cell:	Work:	
ALTERNATE CONTACT:	Name:			
	Relationship:	Phone:		

PERTINENT MEDICAL HISTORY	
Primary Diagnosis/Presenting Problems:	
Pertinent Med History:	
Does this patient need special contact precautions? □ No □ Yes **Reason**:	Date of last negative test:
WCB: □ No □ Yes, Claim #:	SGI: □ No □ Yes, Adjustor Name:
ALLERGIES:	Resuscitation Plan:

Please indicate which disciplines you would like to assess your patient and provide follow-up as needed:

□ **Occupational Therapy**
Therapeutic Goals: _____
_____

□ **Physical Therapy**
Therapeutic Goals: _____
_____

Other services:
- □ Recreational Therapy
- □ Speech Language Therapy
- □ Social Work

Other Goals:

Has a referral been made for Physiatry on the "Referral to Saskatoon Rehabilitation Centre" Form?
□ **Yes** □ **No**

Has there been a referral to any other health care providers involved now or in the past? (i.e.: community therapists or programs, chiropractors, Private Therapy, ABI Program Case Manager, etc.) □ Yes □ No If yes, please Identify:
_____

Is patient in hospital?
□ RUH □ SPH □ SCH □ SCH Inpatient Rehabilitation If in hospital, **planned discharge date**: _____

REFERRING HEALTHCARE PROFESSIONAL INFORMATION		**PRIORITY**
NAME:		This Patient is:
SIGNATURE:		□ **Low Priority** (patient can wait on regular RDS Waitlist)
JOB TITLE:		□ **Moderate Priority** (patient should be seen within 4 weeks) Reason:
PHONE:	FAX:	□ **High Priority / Urgent** (patient should be seen within 2 weeks) Reason: