Brant Community Healthcare System
Outpatient Neurological Rehabilitation Program

Phone:(519)751-5523
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Services Required (Please circle) **PT** **OT** **RN** **SLP**

Patient Information

Name:

Address: Postal Code:

Phone: | Date of Birth: ____________ (dd/mm/yyyy) | Sex: ☐ M ☐ F

Alternate Patient Contact Name:
Relationship to Patient: Phone:

Current Status

Has the patient consented to this referral? ☐ Yes ☐ No
Referral Source: Date:

Condition:
☐ Stroke ☐ Brain Injury ☐ Other: ______________
Detail of Diagnosis: ____
Date of Onset: ____________________ (dd / mm /yyyy)

Is the patient currently in hospital? ☐ Yes Facility: ________________ ☐ No

Admission date: __________________ (dd / mm/ yyyy) | Expected date of discharge: ____________________ (dd / mm / yyyy)

Relevant Medical History/ Medical Precautions/Contraindications for participating in therapy?

☐ No ☐ Yes Explain: ____

Patient Driving Information

Medically fit to drive: ☐ Yes ☐ No

Has the Ministry of Transportation been notified of the patients medical condition?
☐ Yes ☐ No

Priorities for service:

My goals for rehabilitation are:

What areas are you having difficulty with? Please check all that apply:

☐ Arm & hand function ☐ Walking/leg function
☐ Fatigue/ Endurance ☐ Vision and perception
☐ Bathing/ dressing ☐ Concentration/Memory
☐ Safety in the home ☐ Participation in leisure
☐ Swallowing ☐ Knowledge about my diagnosis/illness
☐ Speaking/Understanding ☐ Return to work

Physician Information

Attending Physician Name: Phone:
Family Physician Name: Phone:
Physician Signature:

Revised 31/07/14