

## Outpatient Rehabilitation Services Referral Form

*\*Note: Incomplete or illegible forms will be sent back requesting amendment*

### Patient Information:

Patient Name	
Patient DOB	
Primary Phone #	
Primary Contact <b>if not</b> Patient	Relationship: _____ Phone: _____
Health Card # & Version Code	
OSMH MRN (if applicable)	
Diagnosis: (mandatory)	
Reason for Referral: (mandatory)	

**Service(s) Requested:** Check one program and corresponding criteria. The services below are not for group exercise, falls prevention, activation or to maintain an existing level of functioning.

<input type="checkbox"/> <b>Physiotherapy</b> (Single service only)	<input type="checkbox"/> <b>Community Physiotherapy Clinic (Episode of Care)</b> Check off at least 1 of the following required criteria: <input type="checkbox"/> <19 years of age <input type="checkbox"/> > 65 years of age <input type="checkbox"/> Recently admitted overnight to hospital due to above condition, illness or injury that now requires physiotherapy services. Receiving either: <input type="checkbox"/> ODSP or <input type="checkbox"/> OW (Ontario Works)
	<input type="checkbox"/> <b>Post-Op Elective Total Hip or Knee Replacement / Revision</b> Date of surgery: _____ <input type="checkbox"/> Surgery performed at OSMH (not a requirement) <input type="checkbox"/> Surgery performed at _____
<input type="checkbox"/> <b>Rehab Day Hospital</b> (Must require at least <u>2</u> of the disciplines. Must have: 1) active treatment goals and 2) be able to tolerate 2-3 hours of activity)	<input type="checkbox"/> <b>Occupational Therapy</b> <input type="checkbox"/> <b>Speech Language Pathology</b> <input type="checkbox"/> <b>Physiotherapy</b>
<input type="checkbox"/> <b>Hand Therapy</b>	<input type="checkbox"/> <b>Occupational Therapy</b>

### Referral Information:

Date Sent	
Referring Physician	Physician Name (print): _____ Physician Signature: _____ Physician CPSO #: _____
Office Telephone #	
Office Fax #	