Soldiers' MEMORIAL HOSPITAL Orillia

Apply Patient Label Here with min. of Name, DOB, Health Card #

Outpatient Rehabilitation Services Referral Form

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

Patient Information:

Patient Name:	
Patient DOB:	Health Card #:
Primary Phone #:	OSMH MRN (if applicable):
Patient Address:	
Primary Contact ***if not*** Patient:	Relationship: ___________________ Phone: ___________________
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.

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

Referral Information:

Referring Physician	Physician Name (print): ____ Physician Signature: ____ Physician CPSO #: __________
Office Telephone #	Office Fax #

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