The Rehabilitation Centre / Le Centre de réadaptation

The Ottawa Hospital | L'Hôpital d'Ottawa

THE REHABILITATION CENTRE
505 Smyth, Ottawa, Ontario, K1H 8M2
Admitting Tel: (613)737-7350 ext. 75615
Fax(613) 733-8336

CONSULTATION REQUEST

IDENTIFICATION:

Surname: _____ Name: _____ Maiden: _____ DOB: ____/__/__ Y/M/D

Address: _____ City: _____ Prov.: _____ P.C.:_____

Telephone #: (H) _____ (W) _____ Preferred Language: _____

Health #:_____ Version Code: _____

WSIB #:_____ Date of Accident: _____/___/___

ADDRESSOGRAPH/LABEL

PATIENT'S PRESENT LOCATION: ☐ hospital ☐ nsg home/group home _____ ☐ home
name

IF PATIENT IS MENTALLY INCAPABLE:
Please attach " A consent for Treatment" and Release of Information" forms signed by a substitute decision maker.

CLINICAL INFORMATION

BRIEF MEDICAL SUMMARY (diagnosis and date of onset): _____

_____

_____

_____

_____

_____

_____

_____

Health Professionals presently involved:

Family MD/Specialist☐ Registered Nurse ☐ Psychologist ☐ Physiotherapist☐
Social worker ☐ Speech pathologist ☐ Prosthetist/Orthotist☐ Occupational therapist ☐
Nutritionist☐

CCAC involved? Y☐ N ☐ Other: _____

LIST OF CURRENT MEDICATIONS:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please Turn Over

REASON(S) FOR CONSULTATION REQUEST

Movement

- ☐ ambulation
- ☐ transfers/bed mobility
- ☐ upper extremity; L_R_
- ☐ lower extremity; L_R_
- ☐ back
- ☐ neck
- ☐ acute pain
- ☐ chronic pain
- ☐ driving assessment

Daily Life Activities

- ☐ self care
- ☐ bowel & bladder management
- ☐ pressure sores
- ☐ wound management
- ☐ respiratory care
- ☐ nutrition
- ☐ household activities
- ☐ energy conservation

Interpersonal & Social interaction

- ☐ behavior management
- ☐ emotional functioning/coping
- ☐ family issues
- ☐ financial situation
- ☐ vocational assessment
- ☐ recreation

Equipment

- ☐ home accessibility
- ☐ wheelchair
- ☐ special seating
- ☐ orthotics
- ☐ prosthetics
- ☐ equipment needs

Learning and Applying Knowledge

- ☐ cognitive & perceptual
- ☐ medication issues

Communication

- ☐ speech/communication
- ☐ swallowing
- ☐Technology Access Service

☐ assessment for in-pt. admission

☐ Electromyography

☐ assessment for botox treatment

☐ Other:_____

ATTACH a **COPY** of **INVESTIGATIONS:** (x-rays, consultations to specialists, etc.):

TREATMENT/MANAGEMENT TO DATE OF THE ISSUES IDENTIFIED ABOVE: _____

_____

_____

_____

_____

_____

Referring physician: _____ _____ _____ _____

Signature (OHIP req.) Address (print/stamp) Phone # Fax #

CONTACT FOR APPOINTMENT; if other than patient: _____ _____

name Phone #

Date referral initiated: _____