PROVIDENCE
UNITY HEALTH TORONTO

Referral Form for patients in the Community to access Inpatient Rehab, Outpatient Rehab and Assess and Restore Services

If unsure or if you would like to discuss the application, please contact the Admissions at: **416-285-3744.**

STEP 1: Patient Demographics (Mandatory – ALL FIELDS must be completed or referral will be returned)

Name of Patient: _____ _____ DOB: _____
Last name *First Name* *mm/dd/yy*

Address: _____ Gender:_____

Patient's Phone # (_____)_____ Health Card #:_____

Contact for Booking Appointment: _____ (_____)_____
Name and Relationship *Telephone*

Referral Source: _____
Name and Designation

Organization: _____

Phone #: (_____)_____

Fax #: (_____)_____

☐ Family MD is the same as referral source

Family MD: _____

Family MD's phone #: (_____)_____

Family MD's fax #: (_____)_____

STEP 2: **Location of Patient/Client**: ☐ **Home** ☐ **Inpatient** ☐ **Emergency Department**

STEP 3: Main Concerns/ Diagnosis:

Medication Management:

Cognitive/ Behavioral:

Psychosocial:

Functional:

Services Requested (see page 2):

Inpatient Program ☐

Outpatient Program ☐

Community Outreach* ☐
(*catchment area)

Please provide
Referrer goals:

Patient goals:

STEP 4: Please send us all relevant clinical notes.

Please provide **one** of the following:	Please attach supporting documentation, such as:
☐ GTA Rehab Network Referral form http://www.gtarehabnetwork.ca/referrals	☐ Medical History/ Documents
☐ Resource Matching and Referral form	☐ Diagnostics up to a year ago (CT, MRI, X-ray, US, Labs etc.)
☐ GEM Nurse consult note from the Emergency Department	☐ Relevant Consultation Reports (Geriatrics, Physiatry, Behavioral, Psychiatry/Psychology, etc.)
☐ Providence Healthcare: Assess & Restore Clinic Recommendations	☐ Medication list
☐ Coordinated Care Plan	☐ Relevant Assessments (PT, OT, SW, other)
☐ Relevant Assessments (MD, NP, Case Manager)	☐ Telemedicine Impact Plus Summary
	☐ Assessment Urgency Algorithm (AUA)

Physician/ Primary Health Practitioner

Print Name: Billing #: Tel:

Signature: Date: Fax:

Please FAX the checklist and accompanying documentation to Admissions at **416-285-3759.**

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Please use this checklist when referring to Outpatient and Inpatient Programs from the Community. Applications will be reviewed by a Patient Flow Coordinator and best matched to a program.

Rehabilitative Care Inpatient High and Low Intensity Rehab -
Geriatric and Medical, Orthopaedic and Amputee, Stroke and Neuro.
*** Referrals must be completed by a physician &/ or NP**
Our rehabilitation programs focus on providing our patients, clients and their families, with the interventions, treatment, resources and supports to optimize recovery. Our programs are supported by skilled Interprofessional teams including Registered Nurses, Registered Practical Nurses, Occupational Therapists, Physiotherapists, Therapeutic Recreationists, Social Workers, Dietitians, Speech Language Pathologists, Pharmacists and Physicians. All patients and families are engaged in identifying goals, planning care and the ongoing review of progress planning and discharge. At Providence, planning for discharge starts as early in the path of recovery as possible. An important part of the process is establishing an expected date of discharge and identifying potential barriers to discharge so that the patient/family and their healthcare team have time to resolve the barriers and to best prepare for the transition to home.

Rehabilitative Care – Hospital-Based Outpatient Therapy
*** Referrals must be completed by a physician and/or NP**
Falls Prevention Clinic (Progression) is a client-centred, holistic program that offers comprehensive falls risk assessment, mobility assessment, and treatment program to individuals who have a functional loss as well as identifiable rehabilitation goals. Services could include occupational therapy and physiotherapy, social work, pharmacy, and physician assessment with Care of the Elderly, with the focus to maximize an individual's capability and safety while living in the community

Orthopaedic and Amputee Clinic (Progression) offers consultation, assessment and rehabilitation services to patients with acute musculoskeletal injuries and amputation. Services include pain management, physiotherapy (group and/or individual sessions) and occupational therapy. It also includes an Amputee Assistive Devices Clinic.

Stroke and Neuro Clinic (Progression) offers assessment and rehabilitation services to individuals with recent strokes who are outpatients of Providence Hospital and acute care centres, as well as to individuals with neurological conditions who are outpatients of Providence Hospital.Services include nursing, occupational therapy, physiatry, physiotherapy, speech language pathology, social work and therapeutic recreation (individual and/or group setting.

Assess and Restore (A&R) Services (Progression and Maintenance) * Referrals must be completed by a physician &/or NP

***Frailty Intervention Team (FIT)** consists of an Interprofessional team including a Primary Care Physician with Care of the Elderly, Pharmacist, Physiotherapist, Occupational Therapist, Nurse and Social Worker. The mandate of the FIT is to assess geriatric clients presenting with acute, complex medical issues, and triage them accordingly to avoid unnecessary ED visits and improve outcomes. The physician provides triage, medical assessment, consultation, treatment, referral to a team of allied health professionals (where appropriate) and linkage back to the community physician or referral source. If warranted, the client can be admitted directly to Providence Healthcare's inpatient or outpatient programs. (Physician led)

***Geriatric Medicine Assessment:** The on-site Geriatric Medicine clinic is staffed by a Geriatrician and sees clients with complex medical needs and provides them with a comprehensive geriatric medical assessment, consultation, treatment and linkage back to the primary care physician or referral source. (Dr. Chan & Dr. Yeung)

***Geriatric Psychiatry Clinic** provides assessment, consultation and treatment to geriatric individuals who may have a mental health issue, a dementia syndrome, behavioural or psychosocial issues. Consultation typically occurs in the on-site clinic setting, however home visits may be arranged for homebound individuals, as needed. (Dr. Ferguson)

Medical Management Service is provided by a Certified Geriatric Pharmacist and is designed to optimize therapeutic outcomes for individuals through a clinic or home-based assessment of all aspects of medication use. A comprehensive report is provided to the referral source, including an assessment, summary and recommendations.

Community Outreach* provides a comprehensive home-based assessment by an **Interprofessional team** (Pharmacist, Occupational Therapist, Nurse, Physiotherapist, and Social Worker) **OR with a physician with Care of the Elderly** for geriatric clients with multiple complex medical, functional, and psycho-social conditions in their home. This service provides client-specific recommendations to the Primary Care Physician or referral source, and referral to community partners and services when appropriate.*catchment area