

**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: _____	
<small>Last name</small>	<small>First Name</small>
Address: _____ Gender: _____	
Patient's Phone # (_____) _____ Health Card #: _____	
Contact for Booking Appointment: _____ (_____) _____	
<small>Name and Relationship</small>	<small>Telephone</small>
Referral Source: _____	<input type="checkbox"/> Family MD is the same as referral source
<small>Name and Designation</small>	Family MD: _____
Organization: _____	Family MD's phone #: (_____) _____
Phone #: (_____) _____	Family MD's fax #: (_____) _____
Fax #: (_____) _____	

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

<p><b>STEP 3: <u>Main Concerns/ Diagnosis:</u></b></p>  <p>Medication Management:</p> <p>Cognitive/ Behavioral:</p> <p>Psychosocial:</p> <p>Functional:</p>	<p><b><u>Services Requested</u></b> (see page 2):</p> <p>Inpatient Program      <input type="checkbox"/></p> <p>Outpatient Program      <input type="checkbox"/></p> <p>Community Outreach*      <input type="checkbox"/> (*catchment area)</p> <p><b><u>Please provide</u></b> Referrer goals:</p> <p>Patient goals:</p>
---	--

**STEP 4: Please send us all relevant clinical notes.**

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

<b>Physician/ Primary Health Practitioner</b>		
Print Name: _____	Billing #: _____	Tel: _____
Signature: _____	Date: _____	Fax: _____

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

**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