Toronto Rehabilitation Institute
A University of Toronto
Teaching and Research Hospital

☐ HC ☐ LC ☐ QEC ☐ RC ☐ UC

Spinal Cord Program Outpatient Services Referral Form

Fax: 416.597-7042
Any inquiries please call 416.597.3422 ext: 6188 or 6151

Is the patient currently an inpatient? ☐ Yes ☐ No Facility: ____________ Previous Toronto Rehab Patient: ☐ Yes ☐No

Name: ____________ ____________ ☐ Male ☐ Female MRN#: ____________
Surname Given name

Address: ________________________________
Street name and number City/Town Province/ Country Postal Code

Telephone Number: _(____)____________(____)____________(____)____________
Home Business Alternate

Health Card #: ____________ Version: ________ Date of Birth: ____/____/____
Year Month Day

WSIB Claim #: ____________ WSIB Caseworker: ____________Contact # ____________

Interpreter required? ☐ Yes ☐ No if yes, what language? ____________
Rehab consultant? ☐ Yes ☐ No if yes, name and contact # ____________
CCAC involvement? ☐ Yes ☐ No if yes, name and contact # ____________
Diagnosis: ________________________________
____________ Type of spinal cord injury: ☐ Complete ☐ Incomplete Level: ________

Date of Injury/Event: ____/____/____ Was this injury work related? ☐ Yes ☐ No
Year Month Day

Type of Injury/Event: ☐ MVC ☐ MVC (Bicycle/Pedestrian) ☐Fall ☐ Assault ☐ Sport ☐ Trauma ☐ Non-trauma

TRANSPORTATION

Mode of transportation for attending service/therapy: ☐ Taxi ☐ Wheel trans ☐ Car ☐ Other ____________

Wheel trans applied for: ☐ Yes ☐ No Wheel trans number: ____________

SPECIAL CONSIDERATIONS / PRECAUTIONS / PAST MEDICAL HISTORY:

☐ Allergies: ____________ Surgery: ____________
☐ Past Medical History ____________
____
☐ Autonomic Dysreflexia ☐ Yes ☐ No Infection Control: ☐ MRSA ☐ C -Difficile ☐ VRE ☐ Other

MEDICATION

Name and dosage Indications

____
____
____
____

Height: ____________Weight: ____________

Mobility Status: ☐ Ambulates Independently ☐ Ambulates With Aids/Assistance
☐ Power W/C ☐ Manual W/C
Transfer Status: ☐Independent ☐ Assistance required ☐ Mechanical Lift
History of Falls: ☐ Yes ☐ No

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*Services/clinics marked with an * require additional information section(s) as attached*

Service/Clinic	Reason for referral and/or patient goals
☐ Assistive Technology *	
☐ Bone Density Clinic *	☐ Bone Health Consult And Densitometry ☐ Bone Densitometry Only
☐ Fitness Centre *	
☐ Gynecology Clinic	
☐ Hydrotherapy *	
☐ Nursing	☐ Bowel Teaching ☐ Bladder Teaching ☐ IC Teaching ☐ Bladder Irrigation ☐ Follow Up
☐ Nutrition	
☐ Occupational Therapy	
☐Physiatry Consult	☐ New Patient ☐ Follow-Up
☐ Physiotherapy	
☐ Psychology	
☐ Respiratory Therapy	
☐ Robson Clinic (Urology)	☐ Urology Consult ☐ Urodynamics ☐ Renal Ultrasound ☐ Cystoscopy ☐ Sexuality/Fertility Consult ☐ Other ____ Bladder Management : ☐ Indwelling catheter ☐ Ileoconduit ☐ Voids ☐ Condom catheter ☐ Intermittent catheter If Patient on intermittent catheter, how often? ____
☐ Seating Clinic	
☐ Skin and Wound Clinic	
☐ Speech-Language Pathology	
☐ Social Work	
☐ Therapeutic Day Program*	Patient's must be eligible for 2 or more of these services on an intensive basis ☐ Nursing ☐ Occupational Therapy ☐ Physiotherapy ☐ Social Work
☐ Therapeutic Recreation	

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ASSISTIVE TECHNOLOGY ADDITIONAL INFORMATION

☐ Employed ☐ Unemployed ☐ On Leave ☐ ODSP Employment ☐ ODSP income

Are you interested in exploring employment / school opportunities? ☐ Yes ☐ No

Purpose for Assessment

☐ Personal Writing Needs ☐ Return to School ☐ Return to Work ☐Other ____________________

Current Physical and Functional Status (please describe)

☐ Visual Impairment: ____________________
☐ Cognition Impairment: ____________________
☐ Mobility: ____________________
☐ Handwriting Aids: ____________________
☐ Adaptive Devices for Computer Use: ____________________

Computer Experience:

☐ MS – Based Windows ☐ Mac ☐ Word Processing ☐ Internet ☐ E-mail ☐ None

BONE DENSITY ADDITIONAL INFORMATION

Site: ☐ Spine ☐ Hip ☐ Knee ☐ Wrist ☐ Whole Body

Previous BMD: ☐ Yes ☐ No Date of Last BMD: ______/______/______
year month day

THERAPEUTIC DAY PROGRAM ADDITIONAL INFORMATION

Is the patient currently an inpatient? ☐ Yes ☐ No Facility____________________
If so, what is the anticipated discharge date? ____________________
Date of final family conference? ____________________
Inpatient goal coordinator: ____________________

GOALS FOR THERAPEUTIC DAY PROGRAM

☐ Nursing care/Education: ____________________
☐ Occupational Therapy: ____________________
☐ Physiotherapy: ____________________
☐ Social Worker: ____________________
☐ Other: ____________________

FITNESS CENTRE ADDITIONAL INFORMATION

Based on the current health status of the patient I recommend:

☐ Unrestricted physical activity ____________________
☐ Progressive physical activity ____________________
- with avoidance of: ____________________
- with inclusion of: ____________________

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HYDROTHERAPY ADDITIONAL INFORMATION

Past Medical History: ______________________________

Medication required at the poolside: ______________________________

Contraindications:	Precautions:
☐ Unstable and recent cardiac conditions	☐ Treated Blood Pressure
☐ Seizure disorder	☐ Diabetes
☐ Unstable Blood Pressure	☐ Skin Condition
☐ Pacemaker	☐ Dizziness
☐ Infections - skin or internal	☐ Hearing Impairment
☐ Bladder/Bowel Incontinence	☐ Respiratory Conditions
☐ Chlorine Allergies	☐ Visual Impairment
☐ Fainting	☐ Balance Impairment
☐ Pressure Sore/Open Wounds	☐ Inflammatory Conditions
☐ Foot Tinea/Infections	☐ Autonomic Dysreflexia
☐ Vomiting/Diarrhea	
☐ Other ______________________________	

Describe conditions noted above: ______________________________

Method of transfer: ☐ Stairs ☐ Hydraulic Lift ☐ Mechanical Ceiling Lift

Level of assistance needed: ☐ Independent ☐ Supervision ☐ One Person ☐ Two Persons

Hydrotherapy goals discussed with patient? ☐ Yes ☐ No

Hydrotherapy goals: ______________________________

I certify that my patient____________________ is medically stable and functionally able to participate in hydrotherapy treatment. Furthermore, he/she is safe to take part in therapeutic exercises in a 95 degree Fahrenheit/ 35 degree Celsius heated pool.

I will notify Lyndhurst Centre / Rumsey Centre should my patient's medical status change so that it is no longer medically safe for him / her to participate in the pool.

Referring Physician signature: ______________________ Date of referral: ______________________

FAMILY PHYSICIAN INFORMATION

Name: ______________________ Billing Number: ______________________

Address: ______________________________

Telephone Number: ______________________________

Signature: ______________________________

REFERRING PHYSICIAN INFORMATION

Name: ______________________ Billing Number: ______________________

Address: ______________________________

Telephone Number: ______________________________

Signature: ______________________________