Providence Care

PERSONAL HEALTH INFORMATION

REHABILITATION THERAPY CENTRE
OUTPATIENT REFERRAL

☐ Physiotherapy ☐ Occupational Therapy
☐ Speech Language Pathology ☐ Seating Clinic

Fax referral to Providence Care Central Intake 613-548-5595

ESSENTIAL INFORMATION

Please note an incomplete referral form and missing documentation will result in requests for additional information and a delay in processing your referral. The waiting time varies with the level of priority we assign to your patient.

French Language Services Required?

☐ Yes ☐ No

REFERRING DIAGNOSIS AND SYMPTOMS

ONSET

☐ **TRAUMATIC** _____ Date of Injury: YYYY/MM/DD

Mechanism

_____

_____

☐ **SURGICAL** Date of Surgery: YYYY/MM/DD

Facility where Surgery took place: _____

Procedure				
	☐ Hip Replacement	☐ Left	☐ Right	☐ Bilateral
	☐ Knee Replacement	☐ Left	☐ Right	☐ Bilateral
	☐ Shoulder Replacement	☐ Left	☐ Right	☐ Bilateral
	☐ Reverse Arthroplasty (shoulder)	☐ Left	☐ Right	☐ Bilateral

☐ Other Procedure: _____

_____

☐ **OTHER**

_____

Please check if applicable: ☐ Motor Vehicle Accident (Accident Recovery Centre)

Other relevant information (Surgical/medical conditions, recommendations, precautions, investigation results)

The referring Physician accepts responsibility for ongoing communication and collaboration with the service provider in the care of this patient

Date: YYYY/MM/DD Referring Physician (please print): _____

Time: HH:MM Signature: _____