Providence Care

PERSONAL HEALTH INFORMATION

REHABILITATION THERAPY CENTRE
OUTPATIENT REFERRAL

☐ Physiotherapy

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

ESSENTIAL INFORMATION

Please include the cumulative patient profile (up to date medical history and medication list) where available

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

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☐ **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**

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

<u>Other relevant information</u> (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: ____________________