Brant Community Healthcare System
Outpatient Neurological Rehabilitation Program
Phone:(519)751-5523
Fax: (519)751-5859

Services Required (Please circle) PT OT SW SLP

Patient Information

Name:	Health Card	
Address:		Postal Code:
Phone:	Date of Birth: _____ dd/mm/yyyy	Sex: ☐ M ☐ F
Alternate Patient Contact Name:		
Relationship to Patient:	Phone:	

Current Status

Has the patient consented to this referral? ☐ Yes ☐ No
Referral Source: Date:

Condition:
☐ Stroke ☐ Brain Injury ☐ Other: _____
Detail of Diagnosis: _____
Date of Onset: _____ dd / mm /yyyy

Is the patient currently in hospital? ☐ Yes Facility: _____ ☐ No

Admission date: _____ dd / mm/ yyyy | Expected date of discharge: _____ dd / mm / yyyy

Relevant Medical History/ Medical Precautions/Contraindications for participating in therapy?

☐ No ☐ Yes Explain: _____

Patient Driving Information

Medically fit to drive: ☐ Yes ☐ No

Has the Ministry of Transportation been notified of the patients medical condition?
☐ Yes ☐ No

Priorities for service:

My goals for rehabilitation are:

What areas are you having difficulty with? Please check all that apply:

☐ Arm & hand function	☐ Walking/leg function	☐ Coping with life after injury
☐ Fatigue/ Endurance	☐ Vision and perception	☐ Financial strains/needs
☐ Bathing/ dressing	☐ Concentration/Memory	
☐ Safety in the home	☐ Participation in leisure	
☐ Swallowing	☐ Knowledge about my diagnosis/illness	
☐ Speaking/Understanding	☐ Return to work	

Physician Information

Attending Physician Name:	Phone:
Family Physician Name:	Phone:
Physician Signature:	Date:

Revised December 2023