Regional Acquired Brain Injury Outpatient Services

Physiatry Referral Form

Parkwood Institute, Main Building
P.O. Box 5777, Station B
London, Ontario, N6A 4V2
Phone 519-685-4064 Toll Free: 1-866-484-0445
Fax: 519-685-4824

Referral Date:	Date Referral Received:	Parkwood Institute MR#:

PATIENT'S PERSONAL INFORMATION: (Place sticker here)

Last Name:	First Name: ☐Male ☐Female

Birth Date: (day/month/year)	Age:	☐Single ☐ Married ☐Widowed ☐Separated ☐Divorced

Address- Street:	City:	Province:

Postal Code:	Telephone: (Home)	Telephone: (Other)

E-mail:	Health Card #:

REASON FOR REFERRAL:

MEDICAL INFORMATION:

Date of Injury/onset: (day/month/year)	☐ Traumatic ☐ Non-Traumatic GCS Score: _____ LOC: ☐ Yes ☐ No

Cause of Brain Injury:

☐ Fall ☐ Falling object/From an object ☐ Assault ☐ CVA (Stroke/Aneurysm)
☐ Sports Injury ☐ Motor Vehicle Accident (MVA) ☐ Anoxia ☐ Tumour
☐ Workplace Injury ☐ Other: _____

Has there been 3rd party funding? ☐ Auto Insurance ☐ Private Insurer ☐ WSIB ☐ Other: _____

Please attach relevant medical records of ABI: **Additional Records Faxed with Referral ☐Yes**

☐ CT/MRI of Head ☐ C-Spine Imaging ☐ Emergency/Operative/Consultation Notes ☐ Social Work
☐ Occupational Therapy ☐ Physiotherapy ☐ SLP ☐ Other: _____

☐**Criminal offences or charges** ☐**Violent Behaviour** ☐**Substance Use** ☐**Mental Health Illness**

If yes, please describe: _____

_____

FAX REFERRAL - DATE: (dd/mm/yyyy) _____ (ABI Outpatient Referral)
Last Name: _____ First Name _____
Date of Birth: _____ Age: _____ HIN# _____

History of Seizure: ☐ Yes ☐ No

Allergies: ☐ No ☐ Yes (list) _____

Current Medications: (Include prescription and non-prescription medications)

Medication	Dose (include units)	Route	Frequency	Prescribed by

Medication List Complete: ☐ **Yes** ☐ **No → Additional List Faxed with Referral?** ☐ **Yes**

Relevant medications previously trialed: _____
_____
_____
_____

PAST MEDICAL HISTORY/ISSUES: ☐ None Identified
_____
_____

Have any therapies or treatments been received since the brain injury? ☐ Yes ☐ No

If yes, what therapies/services have been received? ☐Physiotherapy ☐ Occupational Therapy
☐ Massage ☐ Acupuncture ☐ Social Work ☐ Audiologist ☐ Optometrist
☐ Speech Language Pathology ☐ Other: _____

Is there anything else we should be aware of? _____
_____
_____

REFERRING PHYSICIAN (Place sticker here)

Printed Name:	Signature:
Phone:	Fax:

WHAT HAPPENS NEXT?

We will contact you within 7 business days to confirm receipt of your referral and to request missing information. You will receive a notification of the triage decision. **To expedite this process, please ensure that you have provided all requested clinical information and contact information with this referral.**