



**WOODSTOCK HOSPITAL**  
Woodstock, ON

**INTENSIVE REHABILITATION  
OUTPATIENT PROGRAM  
REFERRAL FORM**

PIN # VISIT #  
 PATIENT LAST NAME PATIENT 1ST NAME PATIENT MIDDLE NAME  
 TELEPHONE ADMISSION DATE AND TIME  
 D.O.B. MMM DD YYYY AGE SEX ONT HEALTH CARD #  
 ATTENDING PHYSICIAN  
 FAMILY PHYSICIAN

**FOR OFFICE USE ONLY**

Date received: Date patient contacted: Intake date:

**CLIENT INFORMATION**

Alternate contact: Phone #:  
 Does client consent to referral?  Yes  No Translator required?  Yes  No  
 Name of person filling out this form: Phone # Fax #  
 Client currently resides at:  Hospital  Rehab Unit  Long Term Care  Community  
 Have referrals been made to other agencies / services? If so, please specify:  
 Expected Inpatient Discharge Date (if applicable):  
 Family Physician: Phone #: Fax #:  
 Referring Physician: Phone #: Fax #:

**REFERRAL INFORMATION**

**PLEASE NOTE: The Intensive Rehabilitation Outpatient Program requires recent discharge notes i.e. Occupational Therapy (OT), Physiotherapy (PT), Speech Language Pathology (SLP), Recreation Therapy (Rec T), Social Worker (SW), Dietitian, and any relevant medical reports to accompany this referral. Please include the most recent Functional Independence Measure (FIM) score if available.**

Referring Diagnosis:  
 Date of onset:  
 Hospitalization: History, test results related to referring diagnosis:  See attached

Relevant medical history (include if history of seizures, Vancomycin Resistant Enterococcus (VRE) or Methicillin Resistant Staphylococcus Aureus (MRSA), allergies, etc.):  See attached

Medications / Dosages:  See attached

Requested Services:  PT  OT  SLP  SW  Rec Therapy  Physiatrist  Dietitian

**REHABILITATION GOALS (Expected outcomes, i.e. independent tub transfers , etc.)**

Referring Physician's Signature (required): Date (mmddyyyy):

**FAX COMPLETED FORM TO 519-421-4258 ANY QUESTIONS CALL: 519-421-4206**