Outpatient Rehabilitation Services

170 Colborne Street West, Orillia, Ontario L3V 2Z3 Telephone (705) 327-9153 Fax (705) 327-9140

PATIENT DEMOGRAPHICS

Name _____ Age: _____ D.O.B _____/_____/_____
YY MM DD

Address _____ Telephone (H) _____

City _____ Postal Code _____ Alternate Phone # _____

Health Card # _____ _____
Version Code

Primary Contact: ☐ Patient / ☐ _____ Relationship _____ Telephone (H) _____

DIAGNOSIS *(mandatory)*: _____

REASON FOR REFERRAL *(mandatory)*: _____

SERVICE(S) REQUESTED

(√Check one program, and √corresponding criteria)

The services below are not for: group exercise, activation, falls prevention or to maintain an existing level of functioning

☐ **PHYSIOTHERAPY ONLY**

(Pick One)

☐ **Community Physiotherapy Clinic (Episode of Care)**

(Must meet/check off at least 1 of below criteria)

- ☐ < 19 years of age
- ☐ > 65 years of age
- ☐ Recently admitted to a hospital due to above condition, illness or injury that requires physiotherapy services
- ☐ Receiving ODSP (Ontario Disability Support Program) or OW (Ontario Works) *circle which one*
  Number _____

☐ **Post-Op Elective Total Hip or Knee Replacement / Revision**

- ☐ Surgery done at OSMH *(not a requirement)*

☐ **REHABILITATION DAY HOSPITAL** *(Must require at least 2 of the disciplines below)*

- ☐ **Occupational Therapy**
- ☐ **Speech Language Pathology**
- ☐ **Physiotherapy**

☐ **HAND THERAPY** – Occupational Therapy

Physician/Nurse Practitioner Signature: _____ **Fax #** _____
(Required)

Print Physician/Nurse Practitioner Name: _____ **Date:** _____/____/____
YY MM DD