Providence Care

PERSONAL HEALTH INFORMATION

REHABILITATION THERAPY CENTRE
OUTPATIENT REFERRAL

☐ Occupational Therapy ☐ Speech Language Pathology
☐ Physiotherapy ☐ Seating Clinic

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

ESSENTIAL INFORMATION	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	TO BE COMPLETED BY PROVIDENCE CARE STAFF Interpreter ☐ Family ☐ Professional ☐ Staff ☐ Volunteer Format ☐ Written ☐ Verbal ☐ Both
	Transportation ☐ Drives self ☐ Family ☐ Volunteer ☐ Friend ☐ Other

REFERRING DIAGNOSIS AND SYMPTOMS

ONSET

☐ TRAUMATIC _____ Date of injury YYYY/MM/DD

Mechanism _____

_____

☐ SURGICAL Date of surgery YYYY/MM/DD

Procedure _____

☐ OTHER Date of onset YYYY/MM/DD

_____

_____

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

Other relevant information (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

Time: HH:MM

Referring Physician (please print name): _____

Signature: _____

ACCIDENT RECOVERY CENTER (ARC)

Referral Criteria: Injuries associated with a motor vehicle accident with an active insurance claim. Physician referral required.

Type of Service: Offers an individualized assessment, injury-specific treatment, functionally oriented exercises, education and prevention with the aim of restoring clients to their pre-accident status.

ADULT SEATING CLINIC

Referral Criteria: Patients with complex seating needs that cannot be met in the community.

Type of Service: Inter-professional clinic involving Occupational Therapy and local vendors. Provides initial evaluation of the seating needs of the disabled client with complex problems, recommends appropriate wheelchairs and commercial/custom seating products.

OCCUPATIONAL THERAPY MUSCULOSKELETAL/NEUROLOGICAL

Referral Criteria: Medical referral for patients with any musculoskeletal or neurological condition that affects their ability to manage activities of daily living. Patients must be able to attend therapy appointments at the Hospital and must not be receiving Occupational Therapy Services in the community.

Type of Service: Designed to optimize independence in activities of daily living including self-care, productivity and leisure. Referrals are accepted for patients with a variety of musculoskeletal or neurological conditions. Therapists meet with patients to assess their level of function in activities of daily living, make recommendations for equipment, strategies and adaptive devices and educate the patient and significant others.

PHYSIOTHERAPY OUTPATIENT SERVICES - MUSCULOSKELETAL

Referral Criteria: This service is for individuals who have the following:

- Orthopaedic surgery within 6 months
- Fracture with immobilization within 6 months with limitations in mobility or function
- Anyone over 65 with multiple co-morbidities resulting in recent physical decline in mobility, recent falls, and/or recent hospitalization
- Hand conditions or injuries

Type of Service: Provides Physiotherapy intervention to improve strength, motor control and balance to improve functional mobility with an emphasis on education, prevention and self-management.

PHYSIOTHERAPY OUTPATIENT SERVICES - NEUROLOGICAL

Referral Criteria: Patients who do not require inpatient admission and are able to attend an outpatient program with conditions such as stroke, spinal cord injury, acquired brain injury, ALS, MS, Parkinson's Disease, hand conditions or injuries, and referrals from Spasticity Clinic at PCH.

Type of Service: Provides Physiotherapy intervention to improve strength, motor control and balance to improve functional mobility with an emphasis on education, prevention and self-management.

RESPIRATORY REHABILITATION SERVICE

Referral Criteria: Patients with respiratory disease with functional limitations and shortness of breath with no cardiac or orthopaedic issues that would preclude intensive exercise and have quit smoking or making significant attempt to quit. Must be able to attend 3 times per week for 12 weeks.

Type of Service: Promotes the concept of disease self-management by providing assessment, treatment, inter-professional education and follow-up to patients with respiratory diseases who are optimally medically managed and who continue to experience functional limitations and shortness of breath.

Note: Referrals must be made through Dr. Denis O'Donnell, Respirologist Fax# 613-549-1459

RESPIRATORY - AIRWAY CLEARANCE

Referral Criteria: Patients experiencing difficulty clearing secretions, resulting in increased cough, frequent respiratory infections or increased shortness of breath.

Type of Service: Provides assessment of patients who are experiencing sputum clearance issues. Provides teaching of airway clearance techniques.

SPEECH LANGUAGE PATHOLOGY - OUTPATIENT SERVICE

Referral Criteria: 18 years or older with an acquired neurogenic communication disorder.

Type of Service: Provides assessment, therapy, education, and counseling for adults who have an acquired communication impairment with the goal of improving the patient's functional communication in his/her environment.

VESTIBULAR REHABILITATION

Referral Criteria: Patients with vertigo, motion sensitivity, imbalance, or gaze stability impairments secondary to either peripheral vestibular deficit or a central cause such as traumatic brain injury.