Providence Care

PERSONAL HEALTH INFORMATION

REHABILITATION THERAPY CENTRE
OUTPATIENT REFERRAL

☐ Physiotherapy ☐ Occupational Therapy
☐ Speech Language Pathology ☐ 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

REFERRING DIAGNOSIS AND SYMPTOMS

ONSET

☐ TRAUMATIC ______________________ Date of Injury: YYYY/MM/DD

Mechanism

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☐ **SURGICAL** Date of Surgery: YYYY/MM/DD

Facility where Surgery took place: ______________________

Procedure				
	☐ Hip Replacement	☐ Left	☐ Right	☐ Bilateral
	☐ Knee Replacement	☐ Left	☐ Right	☐ Bilateral

☐ Other Procedure: ______________________

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☐ **OTHER**

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

Other relevant information (Surgical/medical conditions, recommendations, precautions, investigation results)

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The referring Physician accepts responsibility for ongoing communication and collaboration with the service provider in the care of this patient

Date: YYYY/MM/DD Referring Physician (please print): ______________________

Time: HH:MM Signature: ______________________