# Community Stroke Rehabilitation Program

## Referral Form

**Central Intake Office**

Timmins and District Hospital
Outpatient Rehabilitation Department
700 Ross Ave E
Timmins, ON
P4N 8P2
Phone: 705-267-6394
Fax: 705-267-6355

**Program Criteria**

Ontario Resident
18 years or older
Lives at Home or Retirement Home
Stroke within 1 year
Consents to the Program
Achievable Rehab goals
Medically Stable

| **Client Information** | | | |
|---|---|---|---|
| **Name:** | | **Health Card Number:** | |
| **Date of Birth (Age):** | | **Gender:** | |
| **Address:** | | | **Postal Code:** |
| **Phone Number:** | | | |
| **Marital Status:** | | **Work Status:** | |
| **Preferred Language:** | | | |
| **Alternate Contact:** | | | |
| **Current Status** | | | |
| **Client Consents to the Program:** | **Yes** | **No** | |
| **Client Currently in Hospital:** | **Yes** | **No** | |
| **Facility:** | | | |
| **Department:** | | | |
| **Date of Stroke:** | | | |
| **Expected Date of Discharge:** | | | |
| **Expected Discharge Destination:** | | | |
| **Program Involvement** | | | |
| **Disciplines Required:** | **PT** | **OT** | **SLP** |
| **Main Rehab Goals:** | | | |
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **Referral Information** | | | |
| **Referral Date:** | | | |
| **Referral Source (Name, Organization, Department):** | | | |
| **Office Use Only** | | | |
| **Date of Contact:** | | | |
| **Date of Initial Visit:** | | | |
| **Reason for Delay:** | | | |