Outpatient Rehabilitation Referral Form

4255 Laurel Street, Vancouver, BC. V5Z 2G9
Phone: 604-737-6291

****Fax Referral Form to: 604-730-7904****

Demographic label

INCOMPLETE REFERRALS WILL NOT BE PROCESSED AND WILL BE RETURNED
Applications MUST include the following as part of your referral package:

- ☐ **Recent medical history (relevant consults)**
- ☐ **Relevant diagnostic imaging reports**
- ☐ **Medication List**
- ☐ **Relevant therapy assessment/progress notes**

For a list of all GF Strong programs and admission criteria's please go to: www.vch.ca/gfstrong

CLIENT INFORMATION

Client Name: (Last, First)	DOB: (dd/mm/yr)	Gender: ☐ M ☐ F ☐ Other
Address: (#, street, city, postal code)	PHN:	
	Contact Telephone #: Alt. Contact if not client: (Name, Relationship, Phone)	
	Email:	
Referring Physician: ______________________________ Tel.#: Fax #	Family Physician: ___________________________ Tel #:	

Speaks/Understands English? ☐Yes ☐Minimal ☐No   Interpreter: ☐No ☐Yes (Language) :

Is the injury work or motor vehicle accident related? ☐ No ☐ Yes
If yes: Claim organization: Claim #:

MEDICAL STATUS

Primary Diagnosis:	Date of Injury / diagnosis: (dd/mm/yr)
Other medical conditions:	Allergies: ☐ NKA ☐ Yes –List:
	History of falls: ☐ No ☐ Yes Weight bearing status: ☐ WBAT ☐ PWB ☐ NWB

Ongoing or recent history of mental health issues? ☐ No ☐ Yes Ongoing or recent history of drug and/or alcohol use? ☐ No ☐ Yes History of physical/verbal aggression to self or others? ☐ No ☐ Yes	If yes, please comment:

CLIENT REHABILITATION GOALS

List the client's rehab goals or most problematic issues affecting current function:

1.

2.

3.

Referring Physician/Nurse Practitioner Signature: **Date:**