HOME AND COMMUNITY CARE SUPPORT SERVICES
Champlain

Bruyère

Referral Form

Bruyère Outpatient Stroke Rehabilitation /Community Stroke Rehabilitation

Use this referral form for new stroke patients from acute care or inpatient stroke rehabilitation that meet admission criteria for the Bruyère Outpatient Stroke Rehabilitation Program / Champlain Community Stroke Rehabilitation Program.

Admission Criteria

- ✓ 18 years of age or older
- ✓ Onset of stroke < 6 months
- ✓ Valid OHIP card (please contact the Coordinator if patient does not have an OHIP card)
- ✓ FIM >80
- ✓ Able to tolerate a minimum of 60 minutes of therapy (virtual or in person)
- ✓ Demonstrated ability to learn and carry over information
- ✓ SMART goals that are achievable in 8–10-week period
- ✓ Understand English or French
    - If no, accompanied by someone who is competent to interpret for them
- ✓ In person only: Able to manage toileting independently or brings a support to provide assistance
- ✓ For telerehab only: is physically located in Ontario during therapy sessions

Exclusion Criteria

- Ax2 transfers or mechanical lift transfers
- Admitted to Long Term Care

Referral inquiries can be directed to the Coordinator at: 613-562-6262 ext. 1007

Hours of operation: Monday to Friday, 8:00 a.m. to 4 p.m.

Contact us

The Outpatient Stroke Rehabilitation Program
75 Bruyère St., room 321Y
Ottawa, ON, K1N 5C8
Tel.: 613-562-6262, ext. 1758
Fax: 613-562-6312

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Submit completed referral by fax: (613-562-6312)

Does patient consent to referral ☐ Yes ☐ No			
Surname		Given Name	
Health Card #	VC	Province issuing Health Card	
Discharge Date		Expected Discharge Destination	
Rehab ready date (if different than discharge date)			
Address		City	Prov
Postal Code		Gender: ☐ M ☐ F ☐ other	
Telephone		Date of birth	
Address for treatment (if different from home address)			
City	Prov	Postal Code	Alternate phone #
Referring Institution		Referring Physician	
Primary Care Provider			
Contact person to complete an intake screen and schedule appointments			
Relationship to patient		Phone #	
Consent to speak with contact person over the phone ☐ Yes ☐ No			
Secondary Alternate Contact Person		Phone #	
For your alternate contact, check all that apply ☐ POA ☐ SDM ☐ Spouse ☐ No Alternate			
Date of stroke		Location of stroke	
Type of stroke ☐ Ischemic ☐ Hemorrhagic ☐ Unable to determine			
Impairment ☐ Left/Right body ☐ Left body ☐ Right body ☐ No paresis			
Infection control ☐ None ☐ MRSA ☐ VRE ☐ CDIFF ☐ ESBL ☐ TB ☐ Other (specify)			
Precautions: ☐ Yes (i.e. Neurosurgery, Cardiac, Ortho, Swallowing) ☐ Yes ☐ No If Yes, specify			
Follow up appointments booked: ☐ Yes (i.e. Neurology, Neurosurgery, Cardiac, ENT, VFSS) ☐ Yes ☐ No If Yes, specify			

Alpha-FIM® or FIM Score		
Alpha FIM score	Assessment date	☐ No Alpha-FIM data
FIM Score	Assessment date	☐ No FIM data

Surname, First Name _____ DOB _____

Cognitive and Communication Impairment – Check all that apply				
☐ Cognition ☐ Memory ☐ Attention ☐ Executive Function MoCA Score _____/30				
Other				
Visual/Perceptual Neglect ☐ Left ☐ Right Hemianopsia ☐ Left ☐ Right Visual-Spatial ☐ Yes ☐ No				
☐ Communication ☐ Aphasia ☐ Expressive ☐ Receptive ☐ Apraxia ☐ Dysarthria ☐ Cognitive Communication Disorder				
Other				
Swallowing New Dysphagia Post Stroke	☐ Yes	☐ No	Current Diet Texture	

Driving	
Does patient have a valid driver's license? ☐ Yes ☐ No	
Ministry of Transportation notified that patient has a medical condition that may affect their ability to drive? ☐ Yes ☐ No	
Who notified the Ministry? ☐ Physician ☐ OT	
Has the patient been advised not to drive? ☐ Yes ☐ No	
If yes, until when?	By whom?

Other Referrals			
Service	**Reason**	**Service**	**Reason**
Home and Community Support ☐ PSW ☐ RN ☐ OT ☐ PT ☐ SLP ☐ SW		Private services ☐ PSW ☐ RN ☐ OT ☐ PT ☐ SLP ☐ SW	
☐ Aphasia Centre		☐ City of Ottawa ABI Day Program	
☐ Geriatric Psychiatry ☐ Geriatric Assessment		☐ Cardiac/COPD Rehabilitation	
☐ Other, please specify			

Requested discipline involvement	
Discipline	**Focus of Intervention**
☐ OT	
☐ PT	
☐ SLP	
☐ SW	
☐ Rapid Response Nurse (HCCSS)	
☐ Physiatry	
Additional comments	
☐ Physician discharge summary attached (required)	☐ AH discharge summary attached (required)

☐ I have verified that the patient meets the program's admission criteria	
Referral completed by:	Discipline
Telephone #	Date
Signature	Physician Signature