43 Bruyère St. Ottawa ON K1N 5C8

www.bruyere.org

MEDICAL REFERRAL FORM

Palliative Rehabilitation Outpatient Service

Date: ______________________________

Referring Professional: ______________________________

Location: ______________________________

Tel: ______________________________ Fax: ______________________________

❑ Family physician

Family physician name: ______________________________

Private Line #: ______________ Cell /Pag: ______________ Fax: ______________

❑ Other specialist involved in care:

Physician name: ______________________________

Private Line #: ______________ Cell /Pag: ______________ Fax: ______________

PATIENT INFORMATION

Name of patient (please print): ______________________________ DOB: ______________

Address (full): ______________________________

______________________________ Telephone: ______________

OHIP #: ______________________________ Sex: ❑ Male ❑ Female

Language(s): ❑ French ❑ English ❑ Other

CCAC Case Manager (if involved): ______________________________

Diagnosis: ❑ Cancer: ______________________________

❑ Non-Cancer: ______________________________

Reason for referral: ❑ Anorexia ❑ Fatigue/Weakness ❑ Pain ❑ Depression

Summary:

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►***Please return this form <u>with any relevant information</u> by FAX at 613-683-4340*** or email *PallRehab@bruyere.org*

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