Outpatient Acquired Brain Injury Rehab Service: Neuro-Oncology Referral Form

*Items indicated with ** are required eligibility criteria for the program.*
Only referrals meeting all indicated eligibility criteria will be reviewed.

Client Information:	
Name:	
DOB: (dd/mm/yyyy)	Gender: ☐M ☐F ☐Other
Home phone:	Alternate phone:
Address:	
Health Card: VC:	Email:
Alternate Contact Name: Alternate Contact Phone: Primary contact to arrange appointments: ☐ client ☐ alternate contact Consent obtained to arrange appointments with alternate contact: ☐Yes ☐consent not obtained	
Was client's diagnosis made within the past two years, or did client have a recurrence in the past two years: ☐ Yes** ☐ No	
Has client received other outpatient rehab service(s) for this episode of care: ☐ Yes ☐ No**	
Is client mentally, physically and medically stable to participate in therapies regularly, including completion of radiation treatment prior to starting the rehab program: ☐ Yes** ☐ No	
Does client have realistic rehab goals and the potential to improve through program participation: ☐ Yes** ☐ No	
If client requires supervision/assistance for mobility, using the toilet or wayfinding, they have arranged for an Essential Care Partner to attend all in-person appointments: ☐ Yes** **OR** ☐ client does not require supervision/assistance with mobility, using the toilet or wayfinding when attending in-person appointment**	

Medical Information:
Diagnosis: Life expectancy greater than 6 months: ☐ Yes ** *N.B.: wait times for outpatient rehab may be up to 6 months.* ☐ No Is client/family aware of the prognosis? ☐ Yes ☐ No
Date of diagnosis:
Relevant medical/surgical history:

Oncology treatment:
Radiation: ☐completed
☐ongoing: projected end date _____
☐n/a
Chemotherapy: ☐completed
☐ongoing: projected end date _____
☐n/a
Other:

Reason for Referral:

Service(s) requested: ☐ Occupational Therapy ☐ Speech Language Pathology ☐ Physical Therapy
Location: ☐ Hennick Bridgepoint (< 1 yr post injury) ☐ Toronto Rehab (< 2 yrs post injury, 2 or more therapy services)

N.B.: clients will complete an intake assessment with Staff Physiatrist prior to starting the outpatient rehab program

Therapy Goals:
☐ Physical (e.g. upper and/or lower extremity strength and function, mobility, balance, etc.)
☐ Cognition
☐ Communication
☐ Swallowing
☐ Personal care, activities of daily living and/or community living skills
☐ Productivity (e.g. return to school)
☐ Other:_____

Referring Physician Information:

Referring physician:

Phone:	Fax:

Address:

Referring physician signature:

_____

Billing #: Date:

**If not available on Connecting Ontario, the following documentation is required:
- ☐ Relevant medical and consultation reports
- ☐ Admission/discharge notes for recent hospitalizations
- ☐ MRI/CT scans (brain)

**Incomplete referral forms will result in delayed referral response

Please fax this completed referral form and accompanying documentation to:
Toronto ABI Network
Fax: 416-597-7021