

**REQUEST FOR REHABILITATION/ALLIED HEALTH CONSULTATION**

PATIENT NAME: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE: RESIDENCE: ( ) \_\_\_\_\_ BUS : ( ) \_\_\_\_\_  
**ALTERNATE CONTACT:**  
 NAME: \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_  
 PHONE: ( ) \_\_\_\_\_ PHONE: ( ) \_\_\_\_\_  
 RELATIONSHIP: \_\_\_\_\_

HEALTH CARD: \_\_\_\_\_ GENDER: M/F

DATE OF BIRTH: \_\_\_\_\_  
Day Month Year

**FAMILY DR:** \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

**REFERRING DR.:** \_\_\_\_\_ BILLING # \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 TELEPHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

***PLEASE INCLUDE ALL MEDICAL AND REHAB REPORTS***

**Reason for Referral:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Please check services required:**

<input type="radio"/> Occupational Therapy	<input type="radio"/> Pharmacist	<input type="radio"/> Speech-Language Pathology
<input type="radio"/> Physiotherapy	<input type="radio"/> Social Services	<input type="checkbox"/> Swallowing
<input type="radio"/> Dietitian	<input type="radio"/> Counselling	<input type="checkbox"/> Communication

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_