Reset Form

Health PEI

PROVINCIAL AMBULATORY STROKE REHABILITATION SERVICES REFERRAL FORM

Phone: 902-894-2060, Fax: 902-894-2490

LABEL

MRN #_____

DATE: _____

NAME: _____ **CIVIC ADDRESS:** _____

POSTAL CODE:_____ **PHONE#: (H)** _____ **(W)** _____

Referring Physician:_____ **Family Physician:**_____

Appropriate medical investigations have been scheduled (see reverse for list)? ☐ Yes ☐ No

DIAGNOSIS: ☐ Infarct ☐ Hemorrhage **Date of onset:**_____

Risk Factors: ☐ ↑ Blood Pressure ☐ Diabetes Mellitus ☐ Other_____

Co-morbidities_____

Precautions _____

Please attach: 1) Related reports - consults, investigations, if not on Electronic Health Record (EHR)
2) Medication list

Has client/patient been informed of this referral? ☐ **Yes** ☐ **No**

Have the reasons for this referral been explained to the client/family? ☐ **Yes** ☐ **No**

Contact number for family member/care giver: _____

Other Services involved (e.g. Home Care)_____

REASON FOR REFERRAL

☐ **Physiatry Consult** (*require s physician signature)
- ☐ **swallowing**
- ☐ **cognition/perception**
- ☐ **arm and hand function**
- ☐ **mobility** (walking, wheelchair, etc)
- ☐ **transfers** (bed, bath, toilet, etc.)
- ☐ **Instrumental ADL** (homemaking, managing money, etc.)

☐ **Community Rehabilitation Assistant Consult**
- ☐ **speech/language/communication**
- ☐ **behavioral/emotional/financial**
- ☐ **tone / spasticity / pain**
- ☐ **balance** (incl. risk for falls)
- ☐ **self-care** (grooming, dressing, bathing etc.)
- ☐ **vocational / avocational rehabilitation**
- ☐ **Other** _____

*Physician Signature_____

Additional Information/ Specific Goals: **Date of discharge** (if in hospital):_____

☐ **Referral sent to Secondary Prevention Clinic**

Referred by: _____**Signature:** _____

Date: _____ **Phone #:** _____

ORGANIZED CARE STROKE SOINS COORDONNÉS DE L'AVC PRINCE EDWARD ISLAND/ÎLE-DU-PRINCE-ÉDOUARD

See reverse side for Inclusion & exclusion criteria

Send completed form to:
PROVINCIAL AMBULATORY STROKE REHABILITATION SERVICES
c/o Physical Medicine Department
Queen Elizabeth Hospital
PO Box 6600, Charlottetown

The Following information is provided to assist with completing referral form:

Purpose of Provincial Ambulatory Stroke Rehabilitation Clinic:

The stroke survivor requires an assessment/review/follow-up to assist with management of care or access to specific services e.g. admission to rehab unit/district level ambulatory service, trial with botox/splinting, gait training, dysphagia, Constraint Induced Movement Therapy, etc.

Inclusion Criteria:

- The discharge diagnosis from **Acute Stroke Unit** is Stroke **or** confirmation by imaging **or** documented clinical diagnosis by Neurologist, Physiatrist or Internal Medicine Specialist.
- The stroke survivor is medically stable
  - Most responsible physician identifies that patient no longer requires acute care.
  - Cause of stroke is explored; medical investigations completed or in process
  - Secondary prevention/medication plan initiated
  - Comorbid medical conditions managed/stable
  - Patient is not palliative (life expectancy > 6 months)
- The stroke survivor is neurologically stable.
  - to allow for neurological stability,(i.e. completed stroke) stroke survivors must be a minimum of 2 weeks post event.
- Other situations may be considered at the discretion of the team

Exclusion Criteria:

- The individual has a documented diagnosis of TIA.
- The stroke survivor occupies an acute care bed.
- The stroke survivor, family or caregivers are not able to follow through on recommendations.
- The stroke survivor's behavior is inappropriate putting self or others at risk (aggressive, etc.)
- The stroke survivor and/or family decline service.

Medical Investigations:
CT Scan
Carotid Doppler Studies
Echocardiogram
Appropriate Blood work

Please note* - a consultation with physiatry requires a physician's signature

Office Use Only

Date Rec'd: _____ Date Seen:_____

Date Actively Ready for Appointment: _____

Wait time Variance Reason (Choose one of the following):

☐ Declined Program Support
☐ Declined, Canceled or No Show for Earlier offered Appointment
☐ Medical reason
☐ Program Schedule or Capacity Reasons
☐ Unable to Contact Client
☐ Died