

Tips for filling out a referral for the Stroke Tele-Rehab Program

Including the following information on the referral form will assist in timely access to service


Include the following information:

1. All services that the patient will require: Occupational Therapy (OT), Physiotherapy (PT), (Speech Language Pathology (SLP) and/or Social Work)

2. The primary reason for referral and any relevant information

3. If Tele-Rehab Studio or Tele-Rehab In-Home* consultation is requested

*Note – At this time, **In-Home** consultation is only available for remote First Nation communities and client must be enrolled (or eligible to enroll) in the local Home and Community Care Program



ST. JOSEPH'S CARE GROUP
Thunder Bay ON

St. Joseph's Hospital, P.O. Box 3251, Thunder Bay, ON P7B 5G7, (807) 343-2431, Fax (807) 343-0144

OUTPATIENT REFERRAL FORM

NAME: _____ D.O.B. _____
 ADDRESS: _____ PHONE: (home) _____
 DOCTOR: _____ (work) _____
 CONTACT PERSON: _____ PHONE: _____
 INSURANCE NO: (H.C., W.S.I.B., & OTHER) _____

REASON (S) FOR REFERRAL:

<p>DAY PROGRAMS</p> <p><input type="checkbox"/> Chronic Pain Management Program (incl. Fibromyalgia)</p> <p><input type="checkbox"/> Neurology Day Program</p> <p><input type="checkbox"/> Rheumatic Disease Day Program</p> <p><input type="checkbox"/> Day Hospital</p> <p><input type="checkbox"/> Pulmonary Rehab Program</p> <p>AMBULATORY CARE</p> <p><input type="checkbox"/> COPD Clinic</p> <p><input type="checkbox"/> Dermatology Clinic</p> <p><input type="checkbox"/> Drug Therapy Clinic</p> <p><input type="checkbox"/> MS Clinic</p> <p><input type="checkbox"/> Neurology Clinic</p> <p><input type="checkbox"/> Rheumatology Clinic</p> <p><input type="checkbox"/> Wound/Ostomy/Continence Service</p>	<p>OTHER OUTPATIENT SERVICES</p> <p><input type="checkbox"/> Amputee Clinic</p> <p><input type="checkbox"/> Audiology and Hearing Aid Services</p> <p><input type="checkbox"/> Chiropody and Foot Care</p> <p><input type="checkbox"/> Driver Assessment Clinic</p> <p><input type="checkbox"/> Neuropsychology</p> <p><input type="checkbox"/> Occupational Therapy</p> <p><input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Seating Clinic</p> <p><input type="checkbox"/> Speech-Language incl. swallowing</p> <p><input type="checkbox"/> Other ←</p>
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Mobility Status: Independent Wheelchair Cane Walker None Weight Bearing

REFERRING DOCTOR'S SIGNATURE: _____ DATE: _____

RH-16 (Rev. May 2008)

When complete FAX to (807) 343-0144

This is the FAX number for Central Registration at SJCG who manage all out-patient referrals

Check off Other and write in **Stroke Tele-Rehab**

For More Information

- Kyla Turner, Clerk for the Tele-Rehab Program: **phone (807) 346-2334 or via fax at (807) 346-2302** regarding any general information about the Tele-Rehab referral process
- Esmé French, NWO Regional Stroke Network - Thunder Bay Regional Health Sciences Centre: **phone (807) 684-6498** regarding general Tele-Rehab questions
- Trish Nelson, Manager, Physical Rehabilitation Programs, St. Joseph's Care Group: **phone (807) 343-2449** regarding St. Joseph's Care Group programs
- Heather Coulson, Tele-Rehab Project Lead, KO Telemedicine: **phone (807)737-1135 x1580** regarding telemedicine services