Almonte General Hospital

DAY HOSPITAL REFERRAL FORM

Day Hospital is an interdisciplinary therapeutic program. The Day Hospital team offers assessment, treatment and education from Nursing, Physiotherapy, Recreation Therapy, and Occupational Therapy. This referral constitutes a referral to all disciplines. Each program is individually designed to meet their needs.

Name: ____________________

Address: ____________________

DOB: __________ Health Card #: __________

Sex: ___ Marital Status: _______ Phone: __________

Doctor: ____________________

Next of Kin: ____________________

Relationship: __________ Contact #: __________

Alternate Contact Person/#: ____________________

Reason for Referral: ____________________

Recent Hospitalization? (where, when, how long?): ____________________

Goals for this client: ___Rehabilitation; ___ Falls Prevention; ___ Management of Chronic Illness; ___ Delay Deterioration; ___ Community Engagement; ___ Other: ____________________

Primary Diagnosis: ____________________

Secondary Diagnosis: ____________________

Relevant History: ____________________

Please include/attach the following information, if available:

- Patient Profile from office chart
- Medication List
- Relevant reports (consults, test results)

Allergies: ____________________

Mobility Status, incl. assistive devices: __________ Falling >2x in 6 mo? Y N

Communication Skills: ____________________

Mental Status: ____________________

At Home Alone: _____(√) At Home with Others: ____(√):Specify: ____________________

Date of Referral: __________ **Physician's Signature**: ____________________

Physician's Contact Number: ____________________

Please Fax to: 613-256-3483, or

Mail to: Day Hospital, Almonte General Hospital, 75 Spring St., Almonte, Ontario, K0A 1A0

Office Use Only: Referral received: __________ Assessment scheduled for: __________

Jan 2020