UHN | Canada's #1 Hospital

Spinal Cord Program Outpatient Services Referral Form

Fax: 416.597-7042
Any inquiries please call 416.597.3422 ext: 6097

Please note that incomplete referrals will not be processed and will be returned.
Please also send all relevant consult notes and imaging reports.

Name: _____ _____ ☐ Male ☐ Female
Surname Given name

Address: _____
Street name and number City/Town Province/ Country Postal Code

Telephone Number: _(____)_____(____)_____(____)_____
Home Business Alternate

Health Card #: _____ **Version:** _____ **Date of Birth:** _____/_____/_____
Year Month Day

***DIAGNOSIS:** _____
Type of spinal cord injury: ☐ Complete ☐ Incomplete **Level:** _____
***Infection Control Issues**: ☐None ☐MRSA ☐C-Difficile ☐VRE ☐ESBL ☐Other: _____
***Allergies:** _____

Date of Injury/Event: _____/_____/_____
Year Month Day
Type of Injury/Event: ☐ MVC ☐Fall ☐ Assault ☐ Sport ☐ Trauma ☐ Non-trauma

PAST MEDICAL HISTORY (Attach any relevant consult notes and imaging reports)
Surgery:_____
Past Medical History_____
_____
_____
_____

MEDICATION (Attach list if needed)
Name and dosage Indications
_____
_____
_____
_____

COGNITIVE STATUS (please describe any issues with orientation, participation, carryover of new learning, memory, judgment)
_____
_____

Interpreter required? ☐ Yes ☐ No **if yes, what language?** _____
CCAC involvement? ☐ Yes ☐ No **if yes, name and contact #** _____
Was this injury work related? ☐ Yes ☐ No **WSIB Claim #:** _____
WSIB Caseworker Contact # _____
Rehab consultant? ☐ Yes ☐ No **if yes, name and contact #** _____

Mode of transportation for attending service/therapy: ☐ Taxi ☐ Wheel trans ☐ Car ☐ Other _____

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Service/Clinic	MUST indicate reason for referral and complete section
☐ **Bone Health Consult** **Or** ☐ **Bone Health Follow-up**	☐ Bone Densitometry Only ☐ Bone Densitometry & Consult (New patient) ☐ Bone Densitometry & Follow-up **Please also complete and attach CESHA form for ALL Bone Densitometry Scan Requests**
☐ **Electromyography (EMG)**	**Please complete and attach the Neurophysiology Clinic referral form for ALL EMG requests** **Supplemental forms are found at www.uhnca/torontorehab -→ Refer a Patient**
☐ **Nursing**	☐ Bowel Teaching ☐ Bladder Teaching ☐ IC Teaching ☐ Bladder Irrigation ☐ Follow Up
☐ **Nutrition**	
☐ **Occupational Therapy**	Must provide specific and achievable functional rehabilitation goals:
☐**Physiatry Consult**	☐ New Patient or ☐ Existing Patient **If new, please attach supporting documents (ie. Consult notes and imaging reports)**
☐ **Physiotherapy**	Must provide specific and achievable functional rehabilitation goals:
☐ **Respiratory Therapy**	
☐ **Robson Clinic (Urology)** **ALL 4 FIELDS MUST BE COMPLETE TO AVOID RETURN OF REFERRAL**	1. ☐Urodynamics ☐Renal Ultrasound ☐Cystoscopy ☐Urology Consult ☐Uroflow ☐Sexuality/Fertility Consult (Male Only) ☐Other: _____ 2. **Reason for Referral:** ☐Initial Assessment ☐Routine Follow- Up ☐Urgent (State Reason Below) 3. **If uroflow chosen, please indicate how patient transfers** ☐ Standing/crouch pivot transfer ☐ Mechanical lift ☐Sliding board ☐ Other _____ 4. **Bladder Management:** ☐Indwelling catheter ☐Ileoconduit ☐Voids ☐Condom catheter ☐Intermittent catheter → How often? _____
☐ **Seating Clinic**	Please provide specific reason for referral:
☐ **Skin and Wound Clinic**	
☐ **Speech-Language Pathology**	
☐ **Social Work**	

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☐ **Pelvic Health Clinic**	Please indicate referral reason: ☐Pelvic exams ☐ HPV testing ☐STI checks ☐ Consultation (please check all that applies) ☐Vaginal hygiene ☐Contraception ☐Family planning ☐Menopause in the context of SCI ☐Bladder/Bowel management ☐Safe sex practices ☐Education and resources about sexual health and intimacy
☐ **Assistive Technology**	**Impairments of the upper extremities requiring adapted computer for access?** ☐Yes ☐No ☐ Employed ☐ Unemployed ☐ On Leave ☐ ODSP Employment ☐ ODSP income **Are you interested in exploring employment / school opportunities?** ☐ Yes **or** ☐ No **Purpose for Assessment** ☐ Return to School- if so, when? _____ ☐ Return to Work – if so, when?_____ ☐ Personal Writing Needs **Current Physical and Functional Status (please describe)** ☐ Visual Impairment: _____ ☐ Cognition Impairment: _____ ☐ Mobility: _____ ☐ Handwriting Aids: _____ ☐ Adaptive Devices for Computer Use: _____ **Computer Experience:** ☐ MS – Based Windows ☐ Mac ☐ Word Processing ☐ Internet ☐ E-mail ☐ None

FAMILY PHYSICIAN INFORMATION

Name: _____ Billing Number: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Signature: Date:

REFERRING PHYSICIAN INFORMATION ☐ Same as family physician

Name: _____ Billing Number: _____
Address: _____
Telephone Number: _____ Fax Number: _____
Signature: Date: