

# Interprofessional Clinic Clinique Interprofessionnelle



## Referral Form - Adult Services

Fax # 613-526-7126

### Client's Personal Information

First name	Last name	Date of birth (dd/mm/yyyy)	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other:
Address	Apt.	City	Province	Postal Code
Primary phone #	Secondary phone #	Languages spoken <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other (specify)		
Communicates <input type="checkbox"/> verbally <input type="checkbox"/> using a communication tool <input type="checkbox"/> using gestures <input type="checkbox"/> someone responds for him/her				
Mobility: <input type="checkbox"/> without assistance <input type="checkbox"/> with cane <input type="checkbox"/> with walker <input type="checkbox"/> wheelchair		Falls in last month: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how many?		
Is able to come to the clinic? <input type="checkbox"/> No <input type="checkbox"/> Yes				
Diagnosis or medical condition(s)		Insurance Coverage: <input type="checkbox"/> HCAI <input type="checkbox"/> WSIB <input type="checkbox"/> Third Party If Third Party, please specify:		
Referral source (How did you hear about the clinic?) <input type="checkbox"/> Medical Referral <input type="checkbox"/> Online <input type="checkbox"/> Word of Mouth <input type="checkbox"/> Other:				

### Substitute-Decision Maker (if applicable)

First name	Last name	Relationship to client
Telephone # to book appointments		Preferred language <input type="checkbox"/> English <input type="checkbox"/> French

### Reason for Referral

<b>The client shows difficulties with (select all that apply)</b>
Completing daily activities: <input type="checkbox"/> Personal care (hygiene, dressing, meals) <input type="checkbox"/> Household tasks/work/volunteering <input type="checkbox"/> Hobbies
Listening and understanding/comprehension: <input type="checkbox"/> Following conversation in noisy environments <input type="checkbox"/> Feels that others mumble <input type="checkbox"/> Following instructions <input type="checkbox"/> Experiences buzzing/whistling in the ears
Speaking: <input type="checkbox"/> Difficulty finding words <input type="checkbox"/> Change in vocal quality (hoarse/soft voice) <input type="checkbox"/> Clarity of speech
Writing: <input type="checkbox"/> Holding a pen <input type="checkbox"/> Tremors <input type="checkbox"/> Difficulty finding ideas <input type="checkbox"/> Reading (understanding written material)
Physical aspects: <input type="checkbox"/> Walking <input type="checkbox"/> Balance <input type="checkbox"/> Strength <input type="checkbox"/> Stairs <input type="checkbox"/> Return to sport <input type="checkbox"/> Getting out of bed or chair <input type="checkbox"/> Pain (if so, where? _____)
Other: <input type="checkbox"/> Concentration/attention <input type="checkbox"/> Retaining information <input type="checkbox"/> Swallowing/eating/drinking

### Other Rehabilitation Services (please specify)

Previous:
Current:
Waitlist:

### Family Doctor

### Referring Healthcare Provider

First & Last Name	First & Last Name
Address	Address
Telephone #	Telephone #

Updated June 2022