Physician Referral Form

1. To refer, please complete this form and send to 7**78-340-8730 (fax)** or email to **pc@nssrc.org**.
2. The North Shore Stroke Recovery Centre **cannot** support individuals who require assistance with toileting and/or have the following complex needs: medication administration, moderate to severe dementia, other severe health conditions that over-ride the symptoms of a stroke. A caregiver can accompany them to provide the necessary assistance.

Patient Information

Name: _____ D.O.B. (m/d/y) _____/_____/_____

Address: _____ City, PC: _____

Telephone: _____ Cell: _____ Email: _____

Care Card Number: _____ HandyDART #: _____

Next of kin: _____ Telephone: _____

Patient Details

Medical History:

Reason for referral:

Please check all that apply:

☐ Diabetes ☐ Speech difficulties ☐ Hearing difficulties ☐ Vision loss

☐ Swallowing difficulties ☐ Other _____

Mobility: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Independent

Referral Made By

Physician: _____Telephone: _____Date: _____