NORTH SHORE STROKE RECOVERY CENTRE

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:

Cognitive Function:_____

Diabetes: Yes ☐ No ☐ Type:_____Managed? Yes ☐ No ☐

Speech issues ☐ Hearing deficits ☐ Swallowing issues ☐ Allergies ☐

Level of Mobility: Cane ☐ Walker ☐ Wheelchair ☐ Independent ☐

Toileting: Independent? Yes ☐ No ☐

Transportation: Requires HandyDART? Yes ☐ No ☐

Other form of transportation:_____

Speech Therapist Information

Aphasia? Yes ☐ No ☐ Type:_____ Severity: Mild ☐ Moderate ☐ Severe ☐

AAC used?: Yes ☐ No ☐ Effectiveness:_____

Fine motor issues that may impact using AAC device?_____

Vision problems? Visual processing: Yes ☐ No ☐ Double vision: Yes ☐ No ☐

Other:_____

Speech production issues? Apraxia: Yes ☐ No ☐ Dysarthria: Yes ☐ No ☐

Vocal fold paralysis: Yes ☐ No ☐

Voice:_____ Other:_____

Language & cognition? Expressive language: Yes ☐ No Receptive language: Yes ☐ No ☐

Word finding: Yes ☐ No ☐ Memory: Yes ☐ No ☐

Executive functioning: Yes ☐ No ☐

Other:_____

Literacy: Can this person read? Yes ☐ No ☐

At what word level? Single word ☐ Short phrase ☐ Sentences ☐

Dysphagia: Any issues?_____

Referral Made By

Name:_____

Telephone Number:_____

Date:_____