St. Joseph's Care Group

OUTPATIENT REFERRAL FORM

CLEAR PRINT

Place Patient Label with Barcode Here

St. Joseph's Hospital, P.O. Box 3251, Thunder Bay, ON P7B 5G7, (807) 343-2431, Fax (807) 343-0144

NAME: _____ D.O.B. _____

ADDRESS: _____ PHONE: (main) _____

DOCTOR: _____ (other) _____

CONTACT PERSON: _____ PHONE: _____

INSURANCE NO: (HC, WSIB, & OTHER) _____

DIAGNOSIS / REASON(S) FOR REFERRAL:

MOBILITY STATUS:

TRANSPORTATION DETAILS:

CURRENT LOCATION / CONTACT IF DIFFERENT FROM ABOVE:

AMBULATORY CARE PROGRAMS

- ☐ UV Clinic
- ☐ Palliative Care Clinic
- ☐ Injection Drug Clinic
- ☐ Foot Care
- ☐ Chiropody
- ☐ Ostomy

RESPIRATORY PROGRAMS

- ☐ Asthma Clinic
- ☐ COPD Education Clinic
- ☐ Pulmonary Rehabilitation Program
- ☐ Ventilation Clinic

ORTHOPEDIC OUTPATIENT SERVICES

- ☐ Physiotherapy
- ☐ Occupational Therapy

AMPUTEE OUTPATIENT SERVICES

- ☐ Amputee Clinic
- ☐ Single Discipline Therapy (circle) OT PT SW

SPEECH-LANGUAGE OUTPATIENT SERVICES

- ☐ Swallowing Assessment
- ☐ Adult Speech

NEUROLOGY OUTPATIENT SERVICES

- ☐ Neurology Outpatient (Interdisciplinary Therapy)
- ☐ Single Discipline Therapy (circle) OT PT SLP
- ☐ Neuropsychological Assessment (Cognitive Assessment)

RHEUMATIC DISEASES SERVICES

- ☐ Rheumatic Diseases Day Program (Interdisciplinary)
- ☐ Single Discipline (circle) OT PT SW
- ☐ GLA:D (Good Life with Osteoarthritis- Hip & Knee OA)

REGIONAL PROGRAMS

- ☐ Regional Speech (Telemedicine Speech for Stroke / Other Neuro)
- ☐ Stroke Navigator
- ☐ Community-Based Stroke Outreach Team

OTHER OUTPATIENT SERVICES

- ☐ Seating Clinic

Healthcare Provider Signature: _____ Date: _____

Print Healthcare Provider Name: _____

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