

Medical Referral Form

REFERRAL TO

Date: _____ dd / mm / yyyy Referral to: _____
 Focal point: _____ Phone: _____
 Email: _____ Location: _____

REFERRAL FROM

Referral from: _____ Focal point: _____
 Phone: _____ Email: _____
 Location: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____
 Date of birth: _____ dd / mm / yyyy

Gender

Male Female

Phone number: _____ Address of discharge destination (if ... _____

Accompanied by care provider

Yes No

Primary Diagnoses: _____

Other Diagnoses

Treatments Initiated

*Please attach copy of medication chart at discharge or list of current medications (including dose and time of last dose)

List of Medications

Reason for referral

Inpatient Outpatient Community

Transportation needs: _____ Follow-up requirements: _____

FUNCTIONAL STATUS

Mobility

- Bed bound
- Wheelchair
- Crutches
- Walking frame
- Requires assistance
- Independent

Precautions: Such as weight bearing restrictions or spinal precautions: _____

Self-care

- Carer dependent
- Requires commode
- Requires modified latrine/washroom
- Independent

Cognitive impairment

Yes No

Assistive device(s) provided: _____ Assistive device(s) required: _____

Compiled by: _____ Position: _____

Signature

NOTE: This form must accompany the patient's medical file, and a copy of the form should be retained by the referring team.