OUTPATIENT AMPUTEE CLINIC REFERRAL

Date of Referral: _____
MM/DD/YYYY

HELD AT:
PETERBOROUGH REGIONAL HEALTH CENTRE
OUTPATIENT REHABILITATION
1 HOSPITAL DRIVE, PETERBOROUGH, ON K9J 7C6

AMPUTEE CLINIC | FAX: 705-745-7307 | Email: kawartha@pbogroup.ca

CLIENT INFORMATION

PATIENT LABEL

☐ Female **Name**: _____

☐ Male **Date of Birth:** _____
MM/DD/YYYY

Street Address: _____

City/Town: _____ Postal Code: _____

Health Card Number: _____ Telephone Number: _____

Diagnosis/Rx: _____

Date of Surgical Amputation: _____
MM/DD/YYYY

Last Hospital Admission Date: _____
MM/DD/YYYY

Has the client consulted with a Vascular Surgeon for this problem? ☐ Yes ☐ No

Name of Vascular Surgeon: _____ Date last seen: _____
MM/DD/YYYY

Does your patient have diabetes? ☐ No ☐ Yes Type: _____

Does your patient have any pre-existing health condition that would make exercising unsafe, difficult or high risk?

☐ No ☐ Yes, please note: _____

☐ I verify that the above named patient is appropriate to join the PRHC Outpatient Amputee Rehabilitation Program

Referring Practitioner: _____ Telephone: _____
please print clearly

Signature: _____ Date: _____
MM/DD/YYYY

PLEASE ENSURE THAT THE REFERRAL IS FULLY COMPLETED AND SUPPORTING DOCUMENTS ATTACHED BEFORE FAXING TO THE DEPARTMENT.

SUBMIT FORM

For Office Use: K#: _____ Account #: _____ Initials: _____

Form 7028, March 2021