OUTPATIENT AMPUTEE REHABILITATION REFERRAL

PETERBOROUGH REGIONAL HEALTH CENTRE
OUTPATIENT REHABILITATION
1 HOSPITAL DRIVE, PETERBOROUGH, ON K9J 7C6
TEL: 705-740-8351

Date of Referral: ..... MM/DD/YYYY

AMPUTEE CLINIC | FAX: 705-740-8203 | 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: ..... please print clearly Telephone: .....

Signature:..... Date: ..... MM/DD/YYYY

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

SUBMIT FORM

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

Form 7028, October 2019