HÔPITAL Glengarry Memorial HOSPITAL

REQUEST FOR PHYSIATRY CONSULTATION

Fax to 613-525-0147

Address: 20260 County Road 43, Alexandria Ontario

Phone: 613-525-2222 x 4177

PATIENT DEMOGRAPHICS	
Patient Name:	
Date of Birth:	
Gender:	
Address:	
Prov. Health ID #:	
Phone:	
Primary Care Practitioner:	

REFERRING PHYSICIAN	
Name:	
Address:	
Billing #:	
Phone:	
Fax:	
Signature:	

REASON FOR REFERRAL

☐ Stroke Rehabilitation Issue(s) (check all that apply)

☐ Mobility ☐ Shoulder pain ☐ Neuropathic pain ☐ CRPS

☐ Visual field deficit ☐ Cognition ☐ Post-stroke fatigue ☐ Mood changes

☐ Communication ☐ Return to work ☐ Return to driving ☐ Community participation

☐ Other:_____

☐ Spasticity Management

☐ Other: _____

CLINICAL DETAILS

For stroke rehabilitation include date of stroke, brain region affected and suspected etiology if known.
For spasticity please include type of CNS pathology ie/ stroke, traumatic brain injury, spinal cord injury, MS, etc.

☐ Attach current medication list, relevant imaging and laboratory work.