Alberta Health Services

Specialized Rehabilitation Outpatient Program (SROP) - Referral

- Please fax completed form to 780-735-6088 (except for SESD, please see cover sheet)
- Referral must be made by a Physician or Nurse Practitioner

Patient Information			
Last Name	First Name	Middle Name	
Street Address	City	Province	Postal Code
Home Phone	Work Phone	Cell Phone	
Date of Birth	PHN #		

Alternate Contact Information			
Use alternate Contact ☐ Yes ☐ No	Home Phone	Work Phone	Cell Phone
Living Situation *(Lives with)*		Other	
Interpreter Required ☐ Yes ☐ No		Language Spoken	

Reason for Referral

Most Responsible Diagnosis ***(include any pertinent medical history)***

Medical or Activity Restriction ***(i.e. Cardiac concerns)***

Allergies

Community Supports		
Home Care	Day Program	CHOICE
Case Manager	Phone	Other

Referring Physician/Nurse Practitioner		
Name	Phone	Fax
☐ Referral source ***Does Not*** require a copy of the discharge summary		
Family Physician *(if different than above)*	Phone	Fax

Services Requested ***(check all that apply)***

☐ Dietician ☐ Falls Risk for Older People (FROP-Com) ☐ Neuropsychology - Geriatric *(only)*
☐ Nursing ☐ Occupational Therapist Indicate concern _____
☐ Pharmacist ☐ Physical Therapist ☐ Psychologist
☐ Recreational Therapist ☐ Social Worker ☐ Stroke Early Supported Discharge (SESD)
☐ Speech Language Pathologist *(Feeding and Swallowing Services are not available through SROP. A separate referral is required for Glenrose Feeding and Swallowing Services)*

Alberta Health Services

Specialized Rehabilitation Outpatient Program (SROP) - Referral

Rehabilitation

Has patient accessed rehabilitation services in the past 3 months? ☐ Yes ☐ No
if ***Yes*** where _____

Does patient have significant rehabilitation potential? ☐ Yes ☐ No

Does patient demonstrate consistent ability and motivation to participate in active rehab? ☐ Yes ☐ No

Identify Rehabilitation Goals

Falls

Has the patient had two or more slips, trips or falls in the past year? ☐ Yes ☐ No
Details _____

Has the patient have any trouble with walking or balance? ☐ Yes ☐ No
Details _____

Attach Copies of the following *(if available)*

Do Not send information that is available on NetCare

☐ Discharge Summaries ☐ Interdisciplinary Assessment or Progress Notes
☐ Other _____

Referrals made to other Physician/Services/Program *(i.e. Consult to Physiatrist)*

Physician Name	Service/Program	Date *(yyyy-Mon-dd)*	Time *(hh:mm)*	Reason

Cognition

Cognitive Impairment ☐ Yes ☐ No Cognitive Screen/Score _____ / _____ Date *(yyyy-Mon-dd)*
if ***Yes***, describe

Behaviour

Behaviours/mood that may hinder rehabilitation. Describe (i.e. impulsive, subtance abuse, depression, etc.)

Communication

Communication Impairment ☐ Yes ☐ No
If ***Yes***, describe

Current Status *(check all that apply)*

Precautions	☐ Yes ☐ No ☐ MRSA ☐ VRE ☐ CDIFF ☐ Other: _____
Bariatric	☐ Yes ☐ No Weight _____ kg
Visual Impairment	☐ Yes ☐ No ☐ Right ☐ Left ☐ Both Details _____
Hearing Impairment	☐ Yes ☐ No ☐ Right ☐ Left ☐ Both Details _____

Alberta Health Services

Specialized Rehabilitation Outpatient Program (SROP) - Referral

Basic Activities of Daily Living	Independent	Standby Assist	One Person Assist	Two Person Assist
Self-Care				
Transfer				
Ambulation				
Mobility Aids				
Weight Bearing Restrictions ☐ Yes ☐ No If ***Yes***, describe				
Comments				
Include relevant details not captured elsewhere				

Referral Form Completed by	
Print Name	Signature
Contact Number	Date *(yyyy-Mon-dd)*