| Last Name *(Legal)* | First Name *(Legal)* |
|---|---|
| Preferred Name ☐ Last ☐ First | DOB *(dd-Mon-yyyy)* |
| PHN | ULI ☐ Same as PHN / MRN |
| Administrative Gender ☐ Male ☐ Female ☐Non-binary/Prefer not to disclose (X) | |

# Bowel and Bladder Continence Referral (Glenrose Rehabilitation Hospital)

Submit completed form to Glenrose Rehabilitation Hospital by **fax** to 780.735.8873.
For inquiries **call** 780.735.8880 or 780.735.8881.

| **Referring Source** | | |
|---|---|---|
| Source ☐ Self Referral | Phone Number | Fax Number |
| Name of Family Physician | Phone Number | Fax Number |

| **Patient Information** | | | |
|---|---|---|---|
| Last Name | First Name | Current Weight *(kg)* | Phone Number |
| Address | | City/Town | Postal Code |
| Name of Contact Person | | Phone Number | Alternate Number |

**Reason for Referral**

**Medical History** *(Attach Medical History)*

**If any of the responses to the questions below are NO, family are required to attend the clinic appointment.**

**Mobility Status**

Is patient independent with mobility? ☐ No ☐ Yes
Able to get on and off a stretcher? ☐ No ☐ Yes
Able to dress/undress independently? ☐ No ☐ Yes

**Cognitive Status**

Can Patient retain information and give an accurate history? ☐ Yes ☐ No

Is interpreter required? ☐ No ☐ Yes, specify language ______________________________

| **Additional Information** | |
|---|---|
| Name of Home Care Case Manager | Phone Number |
| Name of Pharmacy | Phone Number |
| Medication Profile *(Attach Medication Profile)* | |
| Physician/Nurse Practitioner Signature *(if referral source)* | Date *(dd-Mon-yyyy)* |