Alberta Health Services

Last Name	
First Name	
Date of Birth	
PHN	
Date of Referral	
City	

Rehabilitation Outpatient Referral (Red Deer)

- Please fax completed form to 403-343-4419.
- All sections must be completed in order to process the referral. Incomplete referrals will be returned.

Contact Information ***(select best option for scheduling appointments)***

☐ Client Daytime Phone Number(s):

☐ Alternate *(name)*	Phone
Diagnosis	**Date of Onset**

Functional Concerns, Reason for Referral

Relevant Patient History ***(include related surgical history, recent tests, hospitalizations)***

WCB: ☐ No ☐ Yes | **Interpreter Required:** ☐ No ☐ Yes, *language:*

Alternate Decision Maker ☐ No ☐ Yes, *Name/Phone:*

Services Requested

Physical Therapy
- ☐ Orthopedic / MSK
- ☐ Neurology / Neurofacial
- ☐ Vestibular Rehabilitation
- ☐ Concussion Program
- ☐ Cardiac Rehabilitation
  **requires cardiologist or internist referral*

Occupational Therapy
- ☐ Neurology
- ☐ Driving Evaluation

Speech Language Pathology
- ☐ Swallow Assessment *(with VFSS as required)*
  **VFSS requires Physician or Nurse Practitioner referral*
- ☐ Speech, Language, Voice, Fluency

Interdisciplinary Programs
- ☐ Stroke Rehabilitation
- ☐ Hand / Plastics Rehabilitation

Group Programs *(6 weeks minimum duration)*
- ☐ GLA:D Canada *(hip and knee OA)*
- ☐

Referral Source Information

Name *(print clearly)*	Signature
Professional Designation ☐ Physician	Phone
☐ PT ☐ OT ☐ SLP ☐ NP	Fax
☐ Self-Referral	Email