Last Name	First Name
Birthdate *(yyyy-Mon-dd)*	
PHN#	
Gender ☐ Male ☐ Female	

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	Atlernate 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 *(yyyy-Mon-dd)*

19713 (Rev2018-03)