Alberta Health Services

Spasticity Program for Adults Clinic Referral

Glenrose Rehabilitation Hospital
10230 111 Avenue, Edmonton, AB, T5G 0B7
Phone 780.735.8260 Fax 780.735.6085

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) ☐ Unknown		

■ **Please provide detailed information when possible. All sections must be completed for form to be processed.**

GRH	WCB	Referral Date *(dd-Mon-yyyy)*
Client Address	City	Postal Code
Home Phone	Phone	Other Phone
Contact Person *(to arrange an appointment if different from above)*	Relationship	

Primary Neurological Diagnosis

☐ Stroke ☐ Cerebral Palsy ☐ Brain Injury ☐ MS
☐ Spinal Cord Injury ☐ HSP ☐ Motor Neuron Disease ☐ Other ______________

Date of Onset/Injury *(dd-Mon-yyyy)*

Rehabilitation Information

Mobility

☐ ambulatory ☐ wheelchair ☐ Independent ☐ Mechanical Lift

Does patient fall due to Spasticity? Yes ▼

☐ Once a week ☐ Once a month ☐ Once in 6 months ☐ Once a year

Does patient have wounds caused by or made worse by spasticity? ☐ Yes ▼ ☐ No
Please explain:

Is Patient in active SROP or CRIS? ☐ Yes ▼ ☐ No
If other rehabilitation service, please name:

Has patient received neurotoxin therapy before? ☐ Yes ▼ ☐ No
Please provide date of last injection *(dd-Mon-yyyy)* ______________________________

Is Spasticity interfering with seating or bracing for the patient? ☐ Yes ▼ ☐ No
Please explain:

Major Concerns Related to Spasticity ***(check all that apply)***

☐ **R** upper extremity ☐ **R** lower extremity ☐ **L** upper extremity ☐ **L** lower extremity
☐ **Other** ______________________________

Please identify any other specific problems related to spasticity that you would like the clinic to address below:

Referring Designation/Agency	**Person completing referral**	**Phone**	**Fax**
Referring Physician ***(print name)***	**Signature**	**Phone**	**Fax**