Outpatient Amputee Rehabilitation Referral

Peterborough Regional Health Centre

Outpatient Rehabilitation
1 Hospital Drive
Peterborough, ON K9J 7C6
Phone: (705) 740-8351
Fax: (705) 740-8203

Patient Label

Date of Referral: _____

Please see eligibility criteria on reverse to ensure the referral is appropriate

Patient Name:	Date of Birth (dd/mm/yyyy)	Health Card #:
Address:	Telephone: Home – Cell – Work -	
Diagnosis:	**Date of Surgical Amputation:**	
	Last Hospital Admission Date:	
Has the client consulted with a Vascular Surgeon for this problem: ☐ Yes ☐ No	**Name of Vascular Surgeon:** **Date last seen:**	
Does your patient have diabetes? ☐ NO ☐ YES, Type:_____		
Does your patient have any pre-existing health condition that would make exercising unsafe, difficult or high risk? ☐ No ☐ Yes, please note:_____		
Practitioner's Name (please print):	☑ I verify that the above named patient is appropriate to join the PRHC Outpatient Amputee Rehabilitation Program **Signature of Referring Practitioner**:	
Practitioner's Telephone #:	**Date**:	

Please ensure that the referral is fully completed and supporting documents attached before faxing to the department.

For Office Use: K# _____ Account # _____ Initials _____

KAWARTHA Prosthetics & Orthotics

AMPUTEE CLINIC REFERRAL FORM
FAX TO: (705) 745-7307

210 Hunter Street, Unit 1, Peterborough, ON K9H 2L2 Telephone: (705) 745-1341

CLIENT INFORMATION

☐ Female ☐ Male

Name _____ DOB (MM/DD/YYYY) _____

Street _____ City/Town _____ Postal Code _____

Health Card Number _____ Telephone Number _____

Diagnosis: _____

Amputation Date(MM/DD/YYYY) _____ Amputation Type and Level _____

☐ Left ☐ Right

REFERRAL SOURCE

Referring Physician _____ Telephone _____

Referring Physicians Signature _____ Fax Number _____

Referral Date (MM/DD/YYYY) _____

Please forward any pertinent reports