ST. JOSEPH'S CARE GROUP

OUTPATIENT REFERRAL FORM

Place Patient Label with Barcode Here

St. Joseph's Hospital, P.O. Box 3251, Thunder Bay, ON P7B 5G7, (807) 343-2431, Fax (807) 343-0144

NAME: _____ D.O.B. _____

ADDRESS: _____ PHONE: (home) _____

DOCTOR: _____ (work) _____

CONTACT PERSON: _____ PHONE: _____

INSURANCE NO: (HC, WSIB, & OTHER) _____

REASON(S) FOR REFERRAL:

_____

_____

_____

Mobility Status: ☐ Independent ☐ Wheelchair ☐ Cane ☐ Walker ☐ None – Weight Bearing

DAY PROGRAMS

- ☐ Neurology Day Program
- ☐ Rheumatic Disease Day Program

AMBULATORY CARE

- ☐ Continence Clinic
- ☐ Dermatology Clinic
- ☐ Drug Therapy Clinic
- ☐ MS Clinic
- ☐ Neurology Clinic
- ☐ Ostomy Clinic
- ☐ Rheumatology Clinic
- ☐ Wound Clinic

RESPIRATORY SERVICES

- ☐ Asthma Clinic
- ☐ COPD Education Clinic
- ☐ Pulmonary Rehabilitation Program
- ☐ Ventilation Clinic

OTHER OUTPATIENT SERVICES

- ☐ Amputee Clinic
- ☐ Chiropody
- ☐ Driver Assessment Clinic
- ☐ Foot Care
- ☐ Interprofessional Foot Clinic
- ☐ Neuropsychology
- ☐ Occupational Therapy (OT)
  (circle: Amputee Neurology Orthopaedics)
- ☐ Physiotherapy
  (circle: Amputee Neurology Orthopaedics)
- ☐ Rheumatic Diseases
  (circle: OT PT Social Work)
- ☐ Seating Clinic
- ☐ Speech-Language incl. swallowing
- ☐ Other: _____

REFERRING DOCTOR'S SIGNATURE _____ **DATE** _____

SREFOUTPT