ST. JOSEPH'S CARE GROUP

NORTH WEST REGIONAL REHABILITATIVE CARE OUTREACH PROGRAM (RRCOP)

Shared Care Referral Form

Phone (807) 343-2431 ext 2562 Fax (807) 346-2302

Place Patient Label with Barcode Here

CLEAR PRINT

Patient Information

Name: _____ Last Name: _____ Date of Birth _____

Phone Number _____ Cell Phone Number: _____ Alternate Phone Number: _____

Email Address: _____ Home Address: _____

Community Currently Resides In _____ Health Card Number_____ Status or Band #_____

Identifies As ☐ Male ☐ Female ☐ Other

Triage Level

☐ Urgent (time sensitive) ☐ Routine

Active Offer

Please ask the patient: What is your Mother Tongue? ☐ English ☐ French ☐ Other_____

If not ENG/FRE which language are you most comfortable being served in? ☐ English ☐ French

Consents

☐ Patient has consented to this referral and understands this information will be shared with Central Intake and the therapists in the RRCOP program. As a part of this service, Central Intake will route assessments and care plans to other providers in the circle of care.

☐ Do NOT share information with: _____

Primary Care/Medical Home

Family Doctor or NP _____

☐ Patient does not have a Primary Care Provider *Recommendations will be sent to Primary Care Provider and Referral Source*

Patient Setting

Where is patient currently on the continuum of rehabilitative care? ☐ Ambulatory Outpatients ☐ Inpatient

☐ Home and Community Care ☐ Resident of Long-Term Care **If inpatient**, what is the **Expected Discharge Date**? _____

Shared Care Request

What profession is the request for? Pick One ☐ Occupational Therapy ☐ Physiotherapy ☐ Both

How should consultation occur? Pick One ☐ In-person ☐ Videoconference ☐ Email/phone consult with referring rehab professional

Who should we coordinate visit with? Name _____ Phone_____

Primary Shared Care Rehabilitation Concern:

Please be specific about the SHARED CARE request, include any relevant information, attach any relevant documents

SREFNWRRCOP

Referring Agency_____

Name_____

Profession _____ **Phone** _____

Signature _____ **Date** _____

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