Download and print the form then submit thru email (sw@Lifemark.ca) or fax (416.619.9471)

* **Denotes fields marked as required**

Referral Information

***Referral Date** _____

***Name of Referral Source** _____

Organization Name _____

***Phone Number** _____

Fax Number _____

***Email** _____

***Referral Source**
☐Self ☐Family Member ☐Health Care Provider
☐Ontario Health atHome/HCCSS/LHIN ☐Community Program
☐Hospital ☐Doctor ☐Family Health Team/Clinic ☐ Other

***Client/SDM Approved Referral** ○ Yes ○ No

***Type of Service** ○ PT-OT ○ PT-SLP ○ OT-SLP ○ PT-OT-SLP

LEGEND: PT = Physiotherapy OT = Occupational Therapy SLP = Speech and Language Pathology

Client Information

***Client Name** _____

***Phone Number** _____

***Email** _____

***Street Address** _____

***City** _____

***Date of Birth** _____

***Gender** ○ Male ○ Female ○ Preferred not to say

***Postal Code** _____

***Language** _____

Substitute Decision Maker Information (if required)

SDM Name _____

SDM Phone Number _____

Alternate Phone Number _____

○ Same as client

SDM Email _____

Alternate Email _____

○ Same as client

SDM Address _____

Alternate Address _____

○ Same as client

Medical Information

*Physician Name _____ Physician Fax Number _____

*Physician Phone Number _____ Physician Email _____

*Relevant Medical Diagnosis, History, Interventions /Procedures (please specify)

_____

*Clinical Presentations ○ Nonprogressive ○ Progressive ○ Unknown / Not Applicable

*Relevant Health Concerns (please check all applicable)

- ☐ muscle or joint pain
- ☐ deformity, dislocation, subluxation, sprain / fracture
- ☐ limitation of motion
- ☐ muscle weakness or paralysis
- ☐ muscle stiffness or spasm or spasticity
- ☐ difficulty balance and coordination
- ☐ risks of falls/post fall
- ☐ difficulty in mobility, walking or transfers
- ☐ requires use of assistive devices (cane, walker wheelchair, etc. – please specify) _____
- ☐ requires use of orthotics/prosthesis(braces, splints, etc.- please specify) _____
- ☐ difficulty in fine motor control (hand functions)
- ☐ difficulty with hand coordination (shaking)
- ☐ difficulty in activities of daily living (self-care, bathing, toileting, dressing, eating, cooking, etc.)
- ☐ memory loss/impairments
- ☐ emotional/mental health concerns (low mood, stress, lack of motivation, etc.)
- ☐ difficulty in problem solving in everyday activities or understanding new concepts
- ☐ difficulty in speaking due to paralysis/weakness (slurred or unclear speech, repetition of words/phrases
- ☐ difficulty in formulating, expressing and/or understanding words/sentences
- ☐ words/sentences sounds jumbled / meaningless
- ☐ voice changes (low volume, loud, hoarse, rough, etc.)
- ☐ loss of voice
- ☐ disruptions in the normal flow of speaking (stutters, interjections, prolongations, etc.)
- ☐ difficulty in chewing and/or swallowing liquids/solids
- ☐ acid reflux
- ☐ requires food modifications or avoids certain foods
- ☐ hearing loss/impairments
- ☐ requires the use of communication/hearing devices (please specify) _____
- ☐ others (please specify) _____

Considerations for the program

*Was the client previously enrolled under Lifemark Community Step Up Program? ○ Yes ○ No

*Is the client currently undergoing additional therapy services? ○ Yes ○ No
(if yes, therapy reports may be requested)

* Is the client residing in a Long-Term Care Home? ○ Yes ○ No

*Can the client tolerate a minimum of 60-minute session? ○ Yes ○ No

*Does the client need assistance in mobility/transfers? ○ Yes ○ No

*Does the client need assistance in toileting? ○ Yes ○ No

*Does the client show responsive, impulsive or aggressive behaviors? ○ Yes ○ No

*Is the client able to understand/speak English? ○ Yes ○ No

*Preferred mode of session (depends on availability) ○ In-person ○ Online/Virtual

Other considerations (please specify) _____