UHN Toronto Rehabilitation Institute

Referral Form The Rocket Family Upper Extremity Clinic

Fax Referral Form to 416-597-7111, complete all 4 pages

Research Rx - ☐

Referral Intended for which location? **Lyndhurst Centre** - ☐ **University Centre** - ☐ **No Preference** - ☐

Client Name: _____ _____
(Last / First)

Male: ☐ **Female**: ☐ **Date of Birth:** _____/_____/ _____
year month day

Health Card No.: _____ **Version** (*if any*)**:** _____

Home Address: _____
Postal Code: _____ **Telephone: ( )** _____
Alternate Contact: _____ **Telephone: ( )** _____
(Name and Relation)

Do you have coverage, if yes, please describe: _____
_____

Date of neurological event: _____/_____/ _____
year month day

Diagnosis: _____
Brief Description of neurological event: _____
_____
_____
_____

Referring Physician:
Name: _____
Address: _____
Phone: ( ) _____
Fax: ( ) _____
Billing #: _____

Family Physician:
Name: _____
Address: _____
Phone: ( ) _____
Fax: ( ) _____
Billing #: _____

Referer Signature: _____

Any medical contraindications to receiving Functional Electrical Stimulation (FES)? YES ☐ NO ☐
Please complete the contraindications checklist at the end of the referral as well.

A**ny other medical contraindication for consideration when treating this person for Upper Limb issues?** YES ☐ NO ☐
Comment: _____
_____

Current Medical Consultants and Therapists:

Contact Name	Discipline	Phone

Current Medications:

Name	Dose	Initiated

This page completed by: _____ _____/_____/ _____
print name signature year month day

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PRESENTING SYMPTOMS

UPPER EXTREMITY STATUS:

Is the affected upper extremity the dominant limb? YES ☐ NO ☐ BOTH LIMBS HAVE IMPAIRMENT ☐

Can the client make any type of movement with the limb? YES ☐ NO ☐ Comment:

Does the client use this limb for any day to day activities? YES ☐ NO ☐ Comment:

Has the client been involved in any treatment in the last year for the upper extremity YES ☐ NO ☐
If yes, where:

UPPER EXTREMITY STATUS:	NON-ISSUE	ISSUE	Comment: (IDENTIFY ISSUES)
Paralysis:	☐	☐	
Hypertonicity:	☐	☐	
Hypotonicity:	☐	☐	
Sensation:	☐	☐	
Contractures in Arm:	☐	☐	
Painful Joints:	☐	☐	
Orthopaedic changes in upper extremity:	☐	☐	
Edema:	☐	☐	
Perceptual/Cognitive Challenges	☐	☐	
Inattention/Neglect:	☐	☐	
Apraxia:	☐	☐	
Attention (sustaining attention, dividing attention, alternating attention):	☐	☐	
Other:			

PHYSICAL ISSUES:

Mobility:	☐	☐
Balance:	☐	☐
Pain:	☐	☐
Fatigue:	☐	☐
Dizziness:	☐	☐

OTHER RELEVANT CONDITIONS RELATED TO TREATMENT OF THE UPPER EXTREMITY:

Other: _____

Please attach any additional relevant medical information

Reports Included:

□ MRI	□ OT Report	□ Consult Note	□ Discharge Note
□ CT Scan	□ PT Report	□ X-ray	□ Other:_____

PLEASE FAX COMPLETED REFERRAL FORM TO Central Referral location - 416-597-7111

This page completed by:_____/_____/_____
print name *signature* *year* *month* *day*

Referral Form The Rocket Family Upper Extremity Clinic

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient's name:_____ Date of Birth: _____
Last Name/First Name

Address:_____ Telephone #: _____
Street *City* *Province*

I hereby authorize

_____
name of facility/health services provider releasing information

To provide **The Rocket Family Upper Extremity Clinic, Toronto Rehab – UHN**, with photocopies from my medical record to provide details of treatment received during the time period of _____
Date

to_____for the purposes of review to facilitate treatment.
Date

Expiration Date of Authorization (6 months or as stated):_____/_____/ _____
year *month* *day*

_____ _____ _____
Signature of Patient *Signature of Witness* *Date*

IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO:

_____ _____ _____ _____
Signature of Legal Representative *Relationship* *Name of Witness (Please Print)* *Date*

If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

_____ _____ _____
Signature of Interpreter *Name of Interpreter/Relationship to Patient if any (Please Print)* *Date*

This page completed by:_____/_____/ _____
print name *signature* *year* *month* *day*

Referral Form The Rocket Family Upper Extremity Clinic

July 4, 2018

With this referral, your patient, _____, will potentially be offered therapy with the MyndMove™ Device at the Rocket Family Upper Extremity Clinic. Therefore, further verification regarding contraindications is required. The MyndMove is a multiple channel electrical stimulation device that uses low energy electrical pulses delivered by electrodes placed on the skin to facilitate muscle contractions of the arm. It has approval from Health Canada. If you have made a referral to the Rocket Family Upper Extremity Clinic, please complete this form as well.

In order to use the device safely with the patient there are some things we need to know. Please indicate below if your patient has any restrictions to using the MyndMove™ device by checking the boxes below.

□ Is the patient fitted with a pacemaker, an implantable defibrillator, or an implanted neurostimulation device?
Note: If the patient has passive metallic implants, the therapy can be delivered if the implants are located in an area other than where the electrical stimulation is to be delivered.
□ Does your patient have any cardiac conditions which would contraindicate use of this device
□ Has your patient been treated with botulinum toxin in the last 3 months?
□ Does your patient have any metal implants in her upper extremity.
□ Does your patient suffer from epilepsy?
□ If your patient has seizures that are controlled by medications are you concerned if he/she would have electrical stimulation delivered to his/her arm?
□ Does your patient have any cancerous lesions in the area of the affected arm?
□ Does your patient have any skin conditions on the affected arm such as phlebitis, thrombophlebitis or varicose veins?
□ Does your patient have an unhealed wound or fracture in the affected limb?
□ Does your patient have a cognitive impairment that would affect his/her ability to participate in the therapy session?
□ Are there any other concerns you would have with this patient using this device. If so, please indicate._____
_____
_____
Referrer's Signature Date

_____ _____