

**Spasticity Program for Adults
CLINIC REFERRAL FORM**
Glenrose Rehabilitation Hospital
10230 111 Avenue
Edmonton, AB T5G 0B7
Tel: 780.735.8260 Fax: 780.735.6085

Patient Name: _____
DOB :(DD/MM/YY) _____
GRH #: _____
PHN#: _____
WCB #: _____
M/F: _____

CLIENT DATA:

Address: _____ City: _____ P.C: _____
Telephone (Home): _____ Other: _____
Contact Person (to arrange appointment if different from above): _____
Name: _____ Phone #: _____ Relationship: _____

MAJOR CONCERNS RELATED TO SPASTICITY (check all that apply)

R upper extremity R lower extremity L upper extremity L lower extremity other _____

Please identify specific problems related to spasticity that you would like the clinic to address:

_____ This information was provided by:

_____ Client
_____ Caregiver

PRIMARY NEUROLOGICAL DIAGNOSIS:

Stroke Cerebral Palsy Brain Injury MS Spinal Cord Injury Other

Date of Onset/Injury: _____ Please provide full medication profile

REHAB INFORMATION

Client Weight: _____

Client Mobility: Ambulatory Manual wheelchair Power wheelchair Stretcher

Client Transfers: mechanical lift 1 person assist sliding board independent

Client has been through comprehensive rehab program? Yes No

If Yes, where? _____ When? _____

CLIENT RECEIVING SERVICE FROM:

PT Where: _____ Name: _____ Phone #: _____

OT Where: _____ Name: _____ Phone #: _____

Homecare Where: _____ Name: _____ Phone#: _____

Person completing this form: _____

Designation/Agency: _____

Phone#: _____ Fax: _____

Referring Physician (print name): _____

Referring Physician (signature required): _____

Referring Physician Phone#: _____ Fax: _____