Outpatient Neuro Physiotherapy

PATIENT LABEL

Date of referral: _____

Client's Name: _____ NH Number: _____

Birthdate: _____

Client's Address: _____

Home Phone: _____ Alternative Phone: _____

Alternative Contact:

_____
(Name) (Phone) (Relation)

Client Diagnosis: _____ Date of Onset: _____

Reason for Referral (Tick all that apply):

- ☐ Balance and Falls Prevention
- ☐ Gait re-training
- ☐ Mobility and Transfers
- ☐ Lower Extremity Function
- ☐ Upper Extremity Function
- ☐ Pain Management
- ☐ Spasticity Management
- ☐ Decreased Activity Tolerance

Individual Goals:

_____

_____

_____

Referral Source:

_____
(Name) (Profession) (Contact)

Please Note: The client will be contact for an initial phone consult within 2 weeks of receiving this referral. After which, an appropriate treatment plan will be devised and implemented based off of availability.

OUTPATIENT NEURO PHYSIOTHERAPY

Admission Criteria

- Interest in participating in physical activity
- Medically stable; no limitations to participate in physical activity
- Tolerates >15mins of continuous activity
- Neurological diagnosis including but not limited to Stroke, Parkinson's disease, Multiple Sclerosis, Guillain Barre Syndrome, Functional Neurological Disorder, Acquired Brain Injury etc.