



Institut de réadaptation
en déficience physique
de Québec

Institut universitaire

REFERRAL FORM

Before filing out the form, please refer to the section on the last page entitled « INFORMATION ».

SECTION A

<u>IDENTIFICATION OF REFERRED PERSON</u>	<u>REASONS FOR REFERRAL</u>
FAMILY NAME : _____ GIVEN NAME : _____ Sex : M <input type="checkbox"/> F <input type="checkbox"/> Civil status : _____ Address : _____ _____ Postal code : _____ Phone (home) : _____ Phone (work) : _____ TDD : _____ Date of birth : _____ Medical Ins. number : _____ Exp. : _____ Social Ins. number : _____ <input type="checkbox"/> MSSS <input type="checkbox"/> CSST <input type="checkbox"/> SAAQ <input type="checkbox"/> Others : _____ Claim number : _____ Name of father : _____ Name of mother : _____ Name of spouse/husband : _____ Signifiant other : _____ Relationship : _____ Phone : _____	Referring specialist : _____ Diagnosis : _____ Date of event : _____ Perinatal and/or medical story : _____ _____ _____ Rehabilitation objectives : _____ _____ _____ Has the person received service from the IRDPQ? Yes <input type="checkbox"/> No <input type="checkbox"/> Was the person advised about the referral? Yes <input type="checkbox"/> No <input type="checkbox"/> Was the family advised about the referral? Yes <input type="checkbox"/> No <input type="checkbox"/>
AT TIME OF REFERRAL, THE PERSON WAS LIVING : At home? <input type="checkbox"/> Alone? <input type="checkbox"/> Or with : _____ Foster family? <input type="checkbox"/> Specify : _____ Phone : _____ Group home? <input type="checkbox"/> Specify : _____ Phone : _____ Other <input type="checkbox"/> Specify : _____	COMMENTS : _____ _____ _____ <u>IDENTIFICATION OF REFERRAL AGENT</u> Referral date : _____ Name of referral agent : _____ Relationship with client : _____ Occupation : _____ Phone : _____ Establishment : _____ Address : _____ _____ Postal code _____
OCCUPATION : _____ Employer : _____ Contact : _____ Phone : _____ Education : _____ Retired : _____	_____ SIGNATURE

SECTION B HEARING IMPAIRMENT

Fill out sections : ■ Identification of referred person ■ Referral agent
Please send referral form with the referred person's **audiogram**, taking into account his/her area of origin.

SECTION C VISUAL IMPAIRMENT

Fill out sections : ■ Identification of referred person ■ Referral agent and diagnosis
Please send referral form with the referred person's **oculo-visual assessment report** (no more than a year), taking into account his/her area of origin.

COMMENTS : For persons from the Québec City area and surrounding regions, with a hearing and visual impairment, please ensure that the terms and conditions set for in SECTIONS B and C are met, and forward all documentation to the addresses under "**visual impairment**" adults or children.

SECTION D MOTOR IMPAIRMENT – CHILDREN

Psychomotor development history (age at which he/she started to walk, talk, feed himself/herself, etc.) : _____

Present functional profile (level of autonomy, play, interests, etc.) : _____

Daycare attendance : _____

Schooling : _____

Registered with other organizations (CLSC, association, etc.) : _____

Social status : _____

Comments : _____

DOCUMENTS REQUIRED : ■ Medical consultation reports
 ■ Assessment reports relevant to the referral

SECTION E MOTOR IMPAIRMENT - ADULTS

Are there any problems pertaining to :

- | | |
|---|---|
| <input type="checkbox"/> Judgement | <input type="checkbox"/> Attention |
| <input type="checkbox"/> Concentration | <input type="checkbox"/> Speech/language |
| <input type="checkbox"/> Memory | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Perception of time/space | <input type="checkbox"/> Hearing |
| <input type="checkbox"/> Self awareness | <input type="checkbox"/> Balance |
| <input type="checkbox"/> Orientation | <input type="checkbox"/> Travelling |
| <input type="checkbox"/> Communication | <input type="checkbox"/> Chang. of position |
| <input type="checkbox"/> Feeding | <input type="checkbox"/> Manual tasks |
| <input type="checkbox"/> Continence | <input type="checkbox"/> Housework |
| <input type="checkbox"/> Hygiene | <input type="checkbox"/> Parental roles |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Marital roles |
| <input type="checkbox"/> Physical resistance | <input type="checkbox"/> Reading/writing |

Arms :

- Amputation Movement Sensitivity

Legs :

- Amputation Movement Sensitivity

Muscular tone:

- Spasticity Flaccidity

Skin condition :

- Sore Scar

Comments : _____

Is the person dependent on :

- Technical aids ? Yes No
If yes, which ones ? _____

- A special diet ? Yes No
If yes, which one ? _____

- Special care ? Yes No
What kind ? _____

Rehabilitation prognosis:

- Good
- Moderate
- Doubtful

Refer to upon discharge : _____

REQUEST FOR :

- INPATIENT OUTPATIENT

DOCUMENTS REQUIRED:

- Summary of the medical record
- Summary of the rehabilitation record, if needed
- Summary of the social history
- Consultation and assessment report
- Relevant medical test reports (lab, Rx, etc.)

