Brant Community Healthcare System
Outpatient Rehabilitation
Amputee Program

Phone: (519) 751-5523 **Fax : (519) 751- 5859**

Services Required: ☐ **PT** ☐ **P & O** ☐ **Dr. T. Ballard**

Patient Information

Name:

Address: Postal Code:

Phone:	Date of Birth: _____ dd/mm/yyyy	Sex: ☐ M ☐ F

Alternate Patient Contact Name:
Relationship to Patient: Phone:

Current Status

Has the patient consented to this referral??
☐ Yes ☐ No

Condition:
☐ Above Knee Amputation ☐ Below Knee Amputation ☐ Left ☐ Right

Date of surgery: _____ dd / mm /yyyy Name of Surgeon: _____

Is the patient currently in hospital?
☐ Yes ☐ No Facility: _____

Admission date: _____ dd / mm/ yyyy	Date of discharge: _____ dd / mm / yyyy

Relevant Medical History (Dementia, Hypertension, Depression, etc)

Are there any medical precautions/contraindications for participating in therapy?

☐ No ☐ Yes Explain: _____

Is there any other information you feel we should be aware of?

Physician Information

Attending Physician Name:_____ **Date:**_____

Family Physician Name:_____

Physician Signature:_____