

Brant Community Healthcare System
Outpatient Rehabilitation
Amputee Program

Phone: (519) 751-5523

Fax : (519) 751- 5859

Services Required: PT

P & O

Dr. C. Ballyk

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: _____