Alberta Health Services

Patient label placed here

Name (last, first)
Birthdate (yyyy-Mon-dd)
PHN #

Stroke & Brain Injury Support Team Referral Medicine Hat

Name:		Birthdate:
PHN/ULI:	City/Town:	Phone number:
Physicians involved with care:		
Is patient currently in hospital for stroke/brain injury? ☐ Yes ☐ No		Anticipated discharge date:
Diagnosis/Date of Injury		WCB: ☐ Yes ☐ No
Projected FIM© score (from AlphaFIM©) or FIM© score? (inpatients only)		

Meets program criteria (if ALL are checked)	**Does NOT meet program criteria (if ANY are checked)**
☐ Mild to moderate brain injury or stroke ☐ Willing and able to participate in intensive daily therapy ☐ Resides within approximately 1 hour of Medicine Hat city limits ☐ Medically stable or needs can be supported by Home Care ☐ Cognitively, mentally and physically able to participate	☐ Requires long-term care ☐ Needs best met through another service stream due to clients choice, lifestyle or cognitive abilities ☐ Does not have support to continue functioning safely in home environment

Relevant Concerns/Comments:

Referring Contact Name: ______________________ Signature: ____________________________

Referring Contact Phone Number: ____________________ Date: ______________________

<u>If you are unsure whether your client meets our criteria, please contact us at 403-502-8648 ext 1297</u>

<u>Fax completed referral to: 403-529-8021</u>

Revised February 2023