Capital Health

Patient Name: ____________________
Date of Birth (YYYY/MM/DD): ____________________
Address: ____________________
____
Phone (Home): __________ (Other): __________
HCN: __________ Exp. date__________
HUN: ____________________

Department of Prosthetics and Orthotics

Physician Referral

Nova Scotia Rehabilitation Centre
1341 Summer Street , Halifax, Nova Scotia B4K 4H4 (902) 473 -1299 Fax: (902) 473-1235

☐ Inpatient, Location/Contact ____________________ ☐ Outpatient/Contact ____________________

Service Required:

☐ Prosthetics (artifical limb) ☐ Orthotics (brace) ☐ Pedorthics (footwear or insole)
☐ Consult only ☐ Repair/maintenance ☐ New referral ☐ Replacement

Patient Diagnosis/Prognosis: ____________________
____
____

Patient's physical condition:

☐ Ulcer present
☐ Progressive condition
☐ Growth/physical change
☐ At risk without device
☐ Non-ambulatory
☐ Falls
☐ Other ____________________
____

Treatment required for:

☐ Post-op
☐ Therapy, PT OT
☐ Mobility
☐ Manage Pain
☐ Assist with ADL/Improved function
☐ Return to work/school
☐ Other ____________________
____

Device: ____________________
____
____
____
____

Other Pertinent Information: ____________________
____
____
____

Physician Signature Required

Referral Source (PRINT): ____________________ Signature: ____________________

Contact Phone: ____________________ Date (YYYY/MM/DD): ____________________

Referral Forms
CD2385MR_03_2013