Dr Sami Zaki- Amputee clinic/Intensive Outpatient Rehab

Referral Form

Physical Medicine & Rehabilitation Specialists

502-1515 Dufferin Crescent Nanaimo, BC V9S 5H6

P:(778) 787-1707 / F: (250) 713-4422

Patient Information

Patient Label: Name: Birthdate: MRP: PHN:	Date of Consultation: Patient Location: Hospital- Unit- Bed-

Patient consent has been obtained for this referral: Yes ☐ No ☐

Substitute decision maker contact info:

Name: _____ Relationship to patient: _____

Tel: _____ Email: _____

Diagnoses: (Please list all relevant diagnosis) 1. 2. 3. 4. 5. 6.	Is the patient anticoagulated? Yes ☐ No ☐ If yes, please list the anticoagulant and dose: If on warfarin: Most recent INR: _____ Date of INR: _____ _____ Allergies: Please see attached

Body Region of Concern

	Right	Left	Both
Upper extremity (shoulder, elbow, wrist, fingers)	☐	☐	☐
Lower extremity (hip, knee, ankle, foot, toes)	☐	☐	☐

Other:

Goals of Treatment (check all that apply)

Decrease Pain ☐	Improve seating/positioning ☐	Prevent pressure ulcers ☐
Improve transfers ☐	Improve gait ☐	Improve orthotic fit ☐
Aid in dressing ☐	Aid in hygiene ☐	Other: ☐

Has patient had previous botulinum toxin treatment for spasticity: Yes ☐ No ☐

If yes, when was it last done: _____ (please attach previous treatment note if available)

Current medications and dosages- Please include a list.

Referring Physician Information

Referring Physician:	Physician MSP #
Physician Signature:	Date:

Please Fax to Coastal Rehab and Neurodiagnostics 250-713-4422