

PROVIDENCE PLACE
Moose Jaw, SK
100 2ND Ave NE Moose Jaw, SK S6H 1B8, 306-694-8855

MAGUIRE CENTRE MEDICAL PROGRAM REFERRAL FORM

FAX COMPLETED FORM TO: 306 694 1716

Name: _____ Age _____ Date of Birth: _____

Address: _____ Postal Code: _____

Telephone: _____ SHSP: _____ Sex: _____

Next of Kin/Contact Person: _____ Telephone: _____

Community Agencies involved in client's care: _____

Family Physician: _____ Date of last hospital admission: _____

Is regular blood work being done? Yes No

What tests? _____ Frequency: _____

DIAGNOSES AND MEDICAL PROBLEM LIST: (Please attach history and physical, recent information regarding condition to be treated, reports of consultations and recent lab reports):

1. _____
2. _____
3. _____
4. _____

Allergies: _____ Mental Status: _____

MEDICATIONS: (Please include all medications, prescription and non-prescription)

_____	_____
_____	_____
_____	_____
_____	_____

REFERRED FOR:

- | | | |
|---|---|--|
| <input type="checkbox"/> PT | <input type="checkbox"/> Dietitian | <input type="checkbox"/> Parkinson's Disease Program |
| <input type="checkbox"/> OT | <input type="checkbox"/> Falls Prevention Program | <input type="checkbox"/> Cognitive Group |
| <input type="checkbox"/> Social Work | <input type="checkbox"/> Vestibular Screening Program | <input type="checkbox"/> Pool Therapy |
| <input type="checkbox"/> Nursing/Medical Monitoring | <input type="checkbox"/> Cognitive Screening Program | |
| <input type="checkbox"/> SLP | <input type="checkbox"/> Cooking Program | |

DATE: _____

Signature of Referring Physician