

Referral Form The Rocket Family Upper Extremity Clinic

PRESENTING SYMPTOMS

UPPER EXTREMITY STATUS:

Is the affected upper extremity the dominant limb? YES NO BOTH LIMBS HAVE IMPAIRMENT

Can the client make any type of movement with the limb? YES NO Comment:

Does the client use this limb for any day to day activities? YES NO Comment:

Has the client been involved in any treatment in the last year for the upper extremity YES NO

If yes, where:

UPPER EXTREMITY STATUS:	NON-ISSUE	ISSUE	Comment: (IDENTIFY ISSUES)
Paralysis:	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertonicity:	<input type="checkbox"/>	<input type="checkbox"/>	
Hypotonicity:	<input type="checkbox"/>	<input type="checkbox"/>	
Sensation:	<input type="checkbox"/>	<input type="checkbox"/>	
Contractures in Arm:	<input type="checkbox"/>	<input type="checkbox"/>	
Painful Joints:	<input type="checkbox"/>	<input type="checkbox"/>	
Orthopaedic changes in upper extremity:	<input type="checkbox"/>	<input type="checkbox"/>	
Edema:	<input type="checkbox"/>	<input type="checkbox"/>	
Perceptual/Cognitive Challenges	<input type="checkbox"/>	<input type="checkbox"/>	
Inattention/Neglect:	<input type="checkbox"/>	<input type="checkbox"/>	
Apraxia:	<input type="checkbox"/>	<input type="checkbox"/>	
Attention <small>(sustaining attention, dividing attention, alternating attention):</small>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:			

PHYSICAL ISSUES:

Mobility:

Balance:

Pain:

Fatigue:

Dizziness:

OTHER RELEVANT CONDITIONS RELATED TO TREATMENT OF THE UPPER EXTREMITY:

Other: _____

Please attach any additional relevant medical information

Reports Included:

MRI

OT Report

Consult Note

Discharge Note

CT Scan

PT Report

X-ray

Other: _____

PLEASE FAX COMPLETED REFERRAL FORM TO Central Referral location, Attention to Debbie Hebert 416-597-7111

This page completed by: _____ / _____ / _____
print name signature year month day

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

Referral Form The Rocket Family Upper Extremity Clinic

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient's name: _____ Date of Birth: _____
Last Name/First Name

Address: _____ Telephone #: _____
Street City Province

I hereby authorize

_____ *name of facility/health services provider releasing information*

To provide **The Rocket Family Upper Extremity Clinic, Toronto Rehab – UHN**, with photocopies from my medical record to provide details of treatment received during the time period of _____

to _____ for the purposes of review to facilitate treatment.
Date

Expiration Date of Authorization (6 months or as stated): _____ / _____ / _____
year month day

Signature of Patient

Signature of Witness

Date

IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO:

Signature of Legal Representative

Relationship

Name of Witness (Please Print)

Date

If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

Signature of Interpreter

Name of Interpreter/Relationship to Patient if any (Please Print)

Date

This page completed by: _____ / _____ / _____
print name signature year month day

The information contained herein is confidential and no unauthorized person will have access to the information without the consent of the patient/client or substitute decision-maker.

Referral Form The Rocket Family Upper Extremity Clinic

July 4, 2018

With this referral, your patient, _____, will potentially be offered therapy with the MyndMove™ Device at the Rocket Family Upper Extremity Clinic. Therefore, further verification regarding contraindications is required. The MyndMove is a multiple channel electrical stimulation device that uses low energy electrical pulses delivered by electrodes placed on the skin to facilitate muscle contractions of the arm. It has approval from Health Canada. If you have made a referral to the Rocket Family Upper Extremity Clinic, please complete this form as well.

In order to use the device safely with the patient there are some things we need to know. Please indicate below if your patient has any restrictions to using the MyndMove™ device by checking the boxes below.

- Is the patient fitted with a pacemaker, an implantable defibrillator, or an implanted neurostimulation device?
Note: If the patient has passive metallic implants, the therapy can be delivered if the implants are located in an area other than where the electrical stimulation is to be delivered.
- Does your patient have any cardiac conditions which would contraindicate use of this device
- Has your patient been treated with botulinum toxin in the last 3 months?
- Does your patient have any metal implants in her upper extremity.
- Does your patient suffer from epilepsy?
- If your patient has seizures that are controlled by medications are you concerned if he/she would have electrical stimulation delivered to his/her arm?
- Does your patient have any cancerous lesions in the area of the affected arm?
- Does your patient have any skin conditions on the affected arm such as phlebitis, thrombophlebitis or varicose veins?
- Does your patient have an unhealed wound or fracture in the affected limb?
- Does your patient have a cognitive impairment that would affect his/her ability to participate in the therapy session?
- Are there any other concerns you would have with this patient using this device. If so, please indicate. _____

Signature _____

Date _____