Bay #1 6140 AB-2A
Lacombe, AB T4L 2G5
P: (825) 640-8326
F: (403) 407-5832
www.LegacyRehab.ca

Legacy Rehabilitation - Referral Form

Please print or complete electronically and send by fax to (403) 407-5832 or email to Admin@legacyrehab.ca

Patient Contact Information	
Patient Name (Last, First)	PHN
Address	City/PC
Phone	DOB (MM/DD/YY)
Email	

Alternate Contact Information (please contact the person below rather than the patient)	
Contact Person:	Relationship:
Phone (Cell):	Phone (Work):
Reason for Alternate Contact: (Patient Preference, Hearing Difficulties, Cognitive Status, Language Difficulties)	
Referral Discussed with Patient: (Yes, No, Other)	

Reason For Referral

Most Responsible Diagnosis (and pertinent medical history)

Medical or Activity Restrictions (ie., cardiac concerns; lifting limitations)

Allergies

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Medications (please attach a full list if needed ie., driving assessment)		
Services Requested		
☐ Driving Assessment	☐ Cognitive Assessment	☐ Physical/Functional Assessment
☐ Occupational Therapy: Adult/Neurological ☐ Occupational Therapy: Pediatric Therapy	☐ Physical Therapy: __ Neuro ***or*** __ Orthopedic ☐ Physical Therapy: Pediatric Therapy	☐ Speech Language Pathology: Adult/Neurological ☐ Speech Language Pathology: Pediatric Therapy
☐ Other: ____		

Referral Form Completed By	
Print Name	Signature
Contact Number	Date (MM/DD/YY)
Contact Email	Fax Number