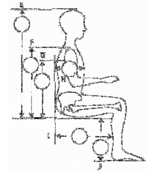
Vancouver CoastalHealth
Promoting wellness. Ensuring care.

G. F. Strong Rehab Centre

SEATING SERVICE REFERRAL FORM

4255 Laurel Street, Vancouver, BC. V5Z 2G9

Fax Referral Form to: 604-730-7904



INCOMPLETE REFERRALS WILL NOT BE PROCESSED AND WILL BE RETURNED
Applications MUST include the following as part of your referral package:

□ **Recent medical history (relevant consults, imaging reports, etc.)** □ **Primary Therapist (OT/PT) assessment/progress notes**	For GF Strong Programs and Admission criteria please go to: www.vch.ca/gfstrong

CLIENT INFORMATION

Client Name: (Last, First)	DOB: (dd/mm/yr)	Gender: ☐ M ☐ F ☐ Other
Address: (#, street, city, postal code) Email:	PHN: Contact Telephone #: Alt. Contact if not client: (Name, Relationship, Phone)	
Speaks/Understands English? □ Yes □ Minimal □ No	Interpreter: □ No □ Yes (Language) :	

CARE PROVIDER INFORMATION

Referring Physician: ________________ Tel.#: Fax #:	Family Physician: ________________ Tel #:
Primary Therapist (OT/PT): ________________ Tel #: __________ Mobile #: __________	CHC/Facility: ________________ Email: ________________

MEDICAL STATUS

Primary Diagnosis: Date of injury/diagnosis: (dd/mm/yr)	Other medical conditions:
Current wounds /skin risk? □ No □ Yes Relevant behavior or mental health concerns? □ No □ Yes History of physical/verbal aggression? □ No □ Yes	If yes, please comment:
Relevant medications: (i.e., pain/spasticity)	

MEDICAL EQUIPMENT FUNDING INFORMATION

Is the client covered under the HSCL/CLBC program? □ No □ Yes

Is the injury/diagnosis work or motor vehicle accident related? □ No □ Yes

If yes: □ WorkSafeBC □ ICBC Claim #:

SEATING AND MOBILITY GOALS

List the client's seating goals or issues affecting current seating and mobility:

1.

2.

3.

Referring Physician / Primary Therapist Signature: **Date:**