Lions Gate Hospital
part of the Vancouver Coastal Health Authority

Neurological Rehabilitation
OUTPATIENT PROGRAM REFERRAL

Referring Physician: ______________________ Family Physician: ______________________

Name of Patient: ____

Date of Birth: ______________________ Personal Health Number: ______________________
Month Day Year

Address: ____

Phone No: (Home) ______________ (Work) ______________ Alternate #: ______________

W.C.B. Number: ______________________ I.C.B.C. Number: ______________________

Diagnosis: ____

Other Medical Conditions: ____

Psychosocial Problems: ____

Medications: ____

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History: ____

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Purpose for referral: ____

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Services required: O.T. [ ] R.N. [ ] S.W. [ ] P.T. [ ] S-L-P [ ] Other ____________

Remarks: ____

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Date of Referral: ______________________ ______________________
Physician's Signature

Please forward this referral to:

Rehabilitation Services
Lions Gate Hospital
231 E. 15th Street
North Vancouver, B.C.
V7L 2L7

Phone: (604) 984-5915
Fax: (604) 984-5744

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