

Patient Name:	
Contact Person:	
Contact person (ph):_	
Date of Birth: YY	_ MM DD
Address:	
Phone: (h)	(w)
Family Physician:	
HCN:	Exp. Date:
HUN:	

Department of Physical Medicine and Rehabilitation Interdisciplinary Spasticity Management Program Referral

QEII Health Sciences Centre Nova Scotia Rehabilitation Centre 1341 Summer Street, 2nd Floor Halifax, Nova Scotia B3H 4K4 Tel: 902-473-1245 Date of Referral: (yyyy/mm/dd): _____ Fax: 902-473-3204 Diagnosis of spasticity due to (check one): Cerebral palsy Stroke Multiple sclerosis Other: _____ Spinal cord injury Traumatic Brain Injury Presentation of spasticity (check all that apply): (Muscle stiffness, tightness, or contraction in) Upper limb (shoulder, elbow, wrist and hand) Right Left Both Right Left Both Lower limb (thigh, knee, ankle, foot) Goals of treatment (check all that apply): Decrease pain
Improve transfers
Aid in dressing Decrease pain Improve seating Prevention of pressure sores Improve gait pattern Prevention of contractures Aid in hygiene Improve orthosis fit Other: Important medical history/ medications (HTN, A-fib, anticoagulant, etc): INR: Stable unstable Medical report or recent investigations attached Previous therapies tried: (PT, OT, bracing, stretching, medications, chemodenervation): Referring physician: Physician signature:



Referral Forms