# Home Referral to Burke Rehabilitation Hospital

**Screening office# 914-597-2519 Fax# 914-597-2888**

**Name**:______________________________________ **Age:**_______ **Date:**_____________

**Diagnosis**:_______________________________________________________________________

**Please check the appropriate Service/Unit you are referring the patient to: __Pulmonary __Orthopedic, __Neuro, __Medical, __Stroke, __Traumatic Brain Injury, __Spinal Cord Injury**

**Reason for Referral:** ______________________________________________________________

**Past Medical and Surgical History:** __________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

______________________________________________________________

**Functional Status: Does patient require assistance with activities of daily living: Yes/No**

**_____Dressing ____Eating ____Toileting _____ Standing from a chair**

**_____Walking Uses a Device: ___Walker ____Cane ____Crutches**

**What distance can patient walk:**___________________________________________________

**Allergies:**___________________________ **Diet:**_________________ **Dysphagia:** Yes / No

**Medication List (including dosages and frequency**_____________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

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___________________________________________

**Please *COMPLETE AND SEND BACK* a Physical exam within two weeks of making a referral:**

**Including:** X **Physical,** X **EKG,** X **Labs** (CBC, BMP, UA), X **CXR** (if relevant)

I believe that the above patient will benefit from and is medically stable and able to participate in 3 hours of intensive inpatient rehabilitation.

**Physician Name** (print):_____________________________**Signature**:______________________

**Phone #**__________________________________________