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____________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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 #_________________________________________