HEALTH PROFESSIONAL

Brain Injury Society
Education • Support • Housing

Stroke Navigator Program

for Stroke Survivors and Caregivers

REFERRAL & CONSENT FORM

The Stroke Navigator Program is a ***non-medical, community support service*** that assists stroke survivors and their caregivers with the adjustment to life after stroke. The program helps navigate toward community services and resources that can help maximize independence after stroke.
To refer a patient, please complete this form and return it by **FAX** at **250-490-3912**

Name: _____ ☐ M ☐ F

Address: _____City: _____

Phone and/or Email: _____DOB: (YYYY-MM-DD)_____

Family Physician / General practitioner: _____

CLIENT CONSENT:
I hereby give consent for referral to the Stroke Navigator Program

Client Signature: _____ Date: _____

Referral made by:

☐ Inpatient rehab ☐ Acute care ☐ Outpatient rehab ☐ ER ☐ Family Practice

☐ Other _____

Name of person referring: _____Relationship to client: _____

Phone number_____ Date of referral: (YYYY-MM-DD): _____

We will contact the person being referred on this form. If for some reason you want us to contact someone else instead, please provide their name, relationship and contact information:

Name & Relationship: _____ Phone: _____

Please complete the questions on the next page

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Please indicate your commitment to ongoing involvement (check either or both):

☐ I am available for consult ☐ Please provide updates of progress

MEDICAL INFORMATION

Date of stroke: _____ (YYYY-MM-DD)

First Stroke: ☐ Yes ☐ No Date previous stroke: _____ (YYYY-MM-DD)

Deficits previous stroke:

Type of current stroke: ☐ Ischemic Stroke ☐ Hemorrhagic Stroke ☐ TIA

Stroke Location:

Date most recent CT/MRI: _____ (YYYY-MM-DD)

Deficits current stroke / presenting issues:

Other medical information and/or comments:

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