Vancouver CoastalHealth
Promoting wellness. Ensuring care.
G. F. Strong Rehab Centre

ALS Centre – Outpatient Clinic Referral Form

4255 Laurel Street **Phone: 604-737-6320**
Vancouver, BC V5Z 2G9 **Fax: 604-737-6234**

CLIENT DEMOGRAPHICS

Client Name: (Last) (First)	DOB: (Day) / (Month) / (Year)	Gender: ☐ M ☐ F
Home Address (street #, street name, city, postal code):		
Home/Cell Tel.#:	PHN#:	
Referring Physician: Tel.#: Fax #:	Family Physician: Tel.#:	
Primary Contact to Arrange Appointments: Tel.#: Relationship to client: Alternate Contact: Tel.#:		
Speaks & Understands English? ☐ Yes ☐ Minimal ☐ No Interpreter Required: ☐ No ☐ Yes - Language:		
Is the injury work related? ☐ No ☐ Yes – Worksafe Claim # _____ Is the injury a result of a motor vehicle accident? ☐ No ☐ Yes – ICBC Claim # _____		

Reason for Referral: **Date of Onset:**

Medical History and Current Medications:

Allergies: ☐ NKA ☐ Yes - List: _____

Please ensure supporting documentation is included with the referral.
Supporting documentation can include:

☐ Recent medical history (include follow up plans)

☐ Copies of specialty consultations

☐ Copies of diagnostics (CT Scans / MRI, EMG reports) and most recent lab work