King Fahad Medical City
Rehabilitation Hospital

Saudi Arabia

REFERRAL FORM FOR CEREBRAL PALSY (CP) PATIENT

Referring Hospital: ..... **Tel :** **Ext.** **Fax :**	**To :** **KFMC** **Tel :** **01-465-6666** **Ext. 6666** **Fax:** **01-416-2011**

Referring Hospital Emergency Coordinator Name:……...……

Patient (Full) Name:	Age:	Gender:

Saudi National ID Number (Attach legible copy please)											

Location:	☐ER ☐Ward ..… ☐Bed No.:	**MRN:**

Referred to (Specialty): .....

Diagnosis: .....

Developmental History:

When was the delay in development noticed by parents: .....

Developmental Milestones:

MILESTONES	YES	NO	AGE MILESTONES DEVELOPED
Head Control			
Sits independently			
Stands w/ or w/out assistive device			
Walks w/ or w/out assistive device			

Past Treatment History:

1. Has patient received any physical therapy? ☐Yes (If yes, duration: _____) ☐No
2. Does the family do Home Exercise Program (HEP)? ☐Yes ☐No
3. The medication that the child is taking: .....
4. Is the patient using any orthotic or assistive device for mobility? ☐No ☐Yes - Please describe them: .....
5. Past surgical history: .....

King Fahad Medical City
Rehabilitation Hospital

Saudi Arabia

REFERRAL FORM FOR CEREBRAL PALSY (CP) PATIENT

Please mention if the child has any of these complications of CP:

GI Problems:

Hearing and vision problems: .....

Seizure: .....

Spasticity and contracture: .....

Cognition: IQ _____ Can the child follow commands or interact with environment ☐Yes ☐No

Speech: Any problem with speech and communication? .....

.....

.....

Muscular skeletal status (as muscle power, range of motion and any deformities) .....

.....

.....

Rehabilitation Service(s) Required:	**Status:** ☐ **Stable** ☐ **Unstable**
....	**Means of Transportation:** ☐ Ambulance ☐ Personal ☐ Others**:** .....

Referring Doctor:	Signature	Date .....

Approved by:	Name and Code	Position:	Signature:

Note1: NO PATIENT will be accepted at KFMC without completing this form from the referring hospital.
Note2: Only Pre Approved Referring Hospital will be accepted

1. Patients' medical problems will be addressed by their respective Pediatricians.
2. Patient will not be referred to other hospitals at KFMC if there is needed referral.
3. Recommendations will, however be made and the clinic will not be responsible for making appointments.
4. Eligibility criteria for children with CP at KFMC:
    - Age from 1-16 years old
    - Should have potential for rehabilitation
    - Should be medically stable
    - Rehabilitation issues may include one or more of the following services:

        a. Seating or other Mobility Devices
        b. Spasticity Management
        c. Physical Therapy
        d. Occupational Therapy
        e. Speech and Language Therapy
        f. Orthotic Management

King Fahad Medical City
Rehabilitation Hospital

Saudi Arabia

REFERRAL FORM FOR CEREBRAL PALSY (CP) PATIENT

☐ Accepted:

☐ Not Accepted:

Reasons: 1. .....
2. .....

Bed No. ..... Ward ..... Hospital	Expected Date/Time of Arrival: KFMC MRN ☐☐☐☐☐☐☐☐☐	Cc: ER Physician Admission Office ER Coordinator Patient Eligibility

Physician Name and code:

Signature: