Locomotor Training Application

Please complete form and return to our Intake Coordinator via fax (519) 685-4066 or email ntrinfo@sjhc.london.on.ca

APPLICANT INFORMATION		**MR#**
Last Name	First	Date
Street Address		City
Province	Postal Code	Phone
Cell	E-mail Address	
Date of Birth	OHIP #	Date of Injury
Family MD:	Phone	
Nature of Injury ABI ☐ SCI ☐ Stroke ☐ Other ☐ _____		
SCI Applicants only: Complete ☐ Incomplete ☐	Level of injury	ASIA Classification

FUNDING INFORMATION: *MOTOR VEHICLE* ☐ ***WSIB*** ☐ ***SELF PAY*** ☐		
Insurance Company	Adjuster	
Claim #	Phone	Fax
Case Manager	Email	
Company	Phone	Fax
Law yer	Email	
Firm	Phone	Fax

MEDICAL INFORMATION		
Do you have medical conditions that would limit you from strenuous exercise? (eg. Heart disease, osteoporosis, wounds, contractures, pain, autonomic dysreflexia)	Yes ☐ No ☐	If Yes please explain below.
Please list any medications you are currently taking.		

FUNCTIONAL STATUS		
Are you walking?	Yes ☐ No ☐	If yes do you need: Walker ☐ Cane(s) ☐ Assistance ☐ Where are you walking? In rehab ☐ Indoors ☐ Community ☐
Do you use a wheelchair?	Yes ☐ No ☐	If yes: Manual chair ☐ Power chair ☐
Are you currently receiving physiotherapy services?	Yes ☐ No ☐	If yes, where?:

Physiotherapist Name	Phone	Email

TRANSPORTATION
Drive own vehicle ☐ Family/Friend ☐ Paratransit ☐ Other ☐
Are you able to consistently attend therapy 4 days per week for 90 minutes? Yes ☐ No ☐

GOALS & EXPECTATIONS
What are you hoping to achieve with Locomotor Training?

OFFICE USE ONLY	
Referral Received	Phone Contact
Comments	
Physiatrist Involved	
Comments	