Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke
Québec
Centre de réadaptation de l'Estrie

300, rue King Est, bureau 200
Sherbrooke (Québec) J1G 1B1
Téléphone : 819 346-8411
Télécopieur : 819 564-7670

REQUEST FOR SERVICES

À L'USAGE DU CRE : N° dossier :
☐ Correction à apporter

TO FACILITATE THE PROCESS, PLEASE ENCLOSE ALL THE NECESSARY DOCUMENTS.

FAMILY NAME: _____

FIRST NAME: _____

DATE OF BIRTH: ____ / ____ / ____
year month day

SEX: M ☐ F ☐

MEDICARE NO.: _____
Expiration date: _____

ADDRESS: _____
Number Street Apt.

_____
Town Postal code

TELEPHONE: *Home:* (___) ATS ☐
Cellular: (___)
Office: *Father:* (___)
Mother: (___) _____
Cellular: *Father:* (___) _____
Mother; (___) _____

E-MAIL: _____

FAX: *Home:* (___) _____

SPOKEN LANGUAGE(S): F ☐ E ☐ *Other:* _____

MARITAL STATUS: _____

PROTECTION PLAN (curator, guardian, counsellor):
Name: _____
Telephone: (___) _____ ext. _____

RESIDENCE:
☐ 1- Home environment (with parents, spouse, children, autonomous environment)
☐ 2- Foster family (name: _____)
☐ 3- Other rehabilitation center (CR) _____
☐ 4- Hospital: _____
☐ 5 - CHSLD (long term care center): _____
☐ 6 - Private placement: _____
☐ 7 - Other (room and board, religious community)

AUTONOMY:
☐ 1- Mobile
☐ 2- Mobile with support device
☐ 3- Mobile with help from another individual
☐ 4 - Wheelchair: ☐ electric
☐ 5 - Wheelchair: ☐ manual ☐ with help ☐ without help
☐ 6 - Confined to bed

COMMUNICATION MODE USED:
☐ 1- Speech and standard print
☐ 2- Speech and large-character print
☐ 3- Speech and braille
☐ 4- Speech and sound track
☐ 5 - Communication table/device
☐ 6 - Bell relay and sign language
☐ 7 - Another individual as intermediary

SIGNIFICANT PERSON(S) TO CONTACT
☐ *Appointment:* *OR* ☐ *Emergency:*

_____ _____
Kinship:
_____ _____
Telephone:
- *Home:* (___) (___)
- *Office:* (___) (___) _____
- *Cell.:* (___) _____ (___) _____

If applicable:

SAAQ NO.: _____

CSST NO.: _____

IVAC NO.: _____

DRIVER'S LICENCE: _____

DATE OF THE ACCIDENT: _____ / ____ / ____
year *month* *day*

STATUS:

☐ **Student:** School: _____
School Board: _____
☐ CPE ☐ Primary ☐ High-school ☐ College ☐ University

☐ **Employed:** Job title: _____
Employer: _____
☐ Full-time ☐ Part-time

☐ **Unemployed**

☐ **Retired**

Mandatory Information
If the request concerns a child:

REQUESTED BY: ☐ *Father* ☐ *Mother*
PARENT TO BE CONTACTED: ☐ *Father* ☐ *Mother*
PARENTS:
Father's name: _____
Mother's name: _____
Address: ☐ *Parents* ☐ *Father* ☐ *Mother*

_____
Number Street Apt.

_____
Town Postal code

Address if different: ☐ *Father* ☐ *Mother*

_____
Number Street Apt.

_____
Town Postal code

Legal guardian:
☐ Mother only ☐ Father only
☐ Other family member (brother, sister)
☐ Other parent ☐ Joint custody

SERVICE(S) REQUESTED

- ☐ Specialized education
- ☐ Speech therapy
- ☐ Physiotherapy
- ☐ Neuropsychology/psychology
- ☐ Visual impairment
- ☐ Social integration
- ☐ Occupational therapy
- ☐ Assessment of driving skills
- ☐ Assessment of working abilities
- ☐ Employment support
- ☐ Intensive functional rehabilitation unit (URFI)
- ☐ Workshops
- ☐ Audiology
- ☐ Social work
- ☐ Medicine
- ☐ Work team
- ☐ Placement
- ☐ Others: _____

N.B. For the Mobility Aid Department (SAM), please use the form specific to the program.

ORIGIN OF THE REQUEST

Name: _____

Date: ____ / ____ / ____
year month day

- ☐ User or his/her family
- ☐ Occupational therapy
- ☐ Physiotherapist
- ☐ Social worker
- ☐ Speech therapist
- ☐ Other, specify: _____
- ☐ Doctor
- ☐ Case manager
- ☐ SAAQ
- ☐ CSST
- ☐ IVAC

Establishment: _____

Your file number: _____

Telephone: (___)

Fax: (___) _____

MAIN DIAGNOSTIC AND RELATED CONDITIONS

Allergies? ☐ No ☐ Yes _____

Is the person MRSA (SARM) carrier? ☐ No ☐ Yes ☐ Unknown

OBJECT OF THE REQUEST

TYPE OF SERVICES RECEIVED *(please check and explain)*

	Actual	***Prior***	***Name of the professional***	***Name of the establishment***
☐ Attending physicians	☐	☐		
☐ Physiotherapy	☐	☐		
☐ Occupational therapy	☐	☐		
☐ Psychosocial services	☐	☐		
☐ Others: _____	☐	☐		

AUTHORIZATION TO FORWARD REPORTS

I, _____ (User / Authorized representative), hereby authorize _____ (Referent / Institution) to forward the current request as well as all other documents required to examine the request to the Centre de réadaptation Estrie. This authorization is valid for a period of _____ (30-60-90) days from the date of signature of this document.

_____ _____ _____

Signature of the user or user's representative | Signature of the witness | Date

Note: Please send this request to the **RECEPTION**:

- by mail: 300, King Street East, Suite 200, Sherbrooke (Quebec) J1G 1B1 *OR*
- by fax 819-564-7670.

For more information, please call **819-346-8411, ext. 43304.**

Reserved for the Centre de réadaptation Estrie

Date: _____ Signature: _____