

# Locomotor Training Application



Please complete form and return to our Intake Coordinator via fax (519) 685-4066 or email [ntrinfo@sjhc.london.on.ca](mailto: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 <input type="checkbox"/>	SCI <input type="checkbox"/>	Stroke <input type="checkbox"/>
	Other <input type="checkbox"/> _____		
SCI Applicants only:	Complete <input type="checkbox"/>	Incomplete <input type="checkbox"/>	Level of injury ASIA Classification

FUNDING INFORMATION: <i>MOTOR VEHICLE</i> <input type="checkbox"/> <i>WSIB</i> <input type="checkbox"/> <i>SELF PAY</i> <input type="checkbox"/>			
<i>Insurance Company</i>		Adjuster	
Claim #	Phone	Fax	
<i>Case Manager</i>		Email	
Company	Phone	Fax	
<i>Law yer</i>		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 <input type="checkbox"/>	No <input type="checkbox"/>
If Yes please explain below.		
Please list any medications you are currently taking.		

Name

MR

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**FUNCTIONAL STATUS**

Are you walking?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes do you need: Walker <input type="checkbox"/> Cane(s) <input type="checkbox"/> Assistance <input type="checkbox"/> Where are you walking? In rehab <input type="checkbox"/> Indoors <input type="checkbox"/> Community <input type="checkbox"/>
Do you use a wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes: Manual chair <input type="checkbox"/> Power chair <input type="checkbox"/>
Are you currently receiving physiotherapy services?	Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, where?:
Physiotherapist Name	Phone	Email

**TRANSPORTATION**

Drive own vehicle <input type="checkbox"/> Family/Friend <input type="checkbox"/> Paratransit <input type="checkbox"/> Other <input type="checkbox"/>
Are you able to consistently attend therapy 4 days per week for 90 minutes? Yes <input type="checkbox"/> No <input type="checkbox"/>

**GOALS & EXPECTATIONS**

What are you hoping to achieve with Locomotor Training?

**OFFICE USE ONLY**

Referral Received	Phone Contact
Comments	
MD Assessment Date	Dr. Sequeira <input type="checkbox"/> Dr. Loh <input type="checkbox"/> Dr. MacKenzie <input type="checkbox"/>
Comments	
LT Assessment Date	Katie <input type="checkbox"/> Kristin <input type="checkbox"/>