Welcome to the Hospital of Central Connecticut Rehabilitation Network. We thank you for choosing us, and we will strive to exceed your expectations and overall results.

During your first visit you will receive a comprehensive evaluation by a licensed Physical, Occupational or Speech Therapist. Your therapist will work with you to identify your functional deficits, from which specific goals will be set. An individual treatment plan will be created specifically for you.

Please keep in mind:

• You are responsible for determining the limits of outpatient rehabilitation benefits and for obtaining any required referral forms. Authorization does not constitute guaranteed payment of charges. The patient is ultimately responsible for any charges and co-pays.

• If you are late for an appointment, we may have to reschedule or shorten your treatment time. If you are unable to attend your appointment, please call 24 hours prior to your appointment.

• **TWO CANCELLATIONS OR NO-SHOW APPOINTMENTS WILL RESULT IN DISCHARGE FROM THE THERAPY PROGRAM.** By scheduling appointments and not attending, it limits the availability for our other patients in need of appointments. In addition, it will interfere with your ability to maximize your results with therapy. You will be required to obtain a new order from the referring physician prior to any future appointments being scheduled.

I understand the above information and am in agreement with this program:

Patient Signature ___________________________________________         Date _____________________

We value your feedback, so if at any time you would like to share your comments or concerns, please do not hesitate to contact me directly.

Robert Stair PT, MBA, Cert MDT
Director
Past Medical History

Patient Name: _____________________________ Date of Birth: __________________ Date: _____________

Cell #: _____________ Carrier (Verizon, Sprint, etc.): _____________ Appt. Reminders?  Text / Email / Call

Primary Care Physician: ___________________  PCP phone number: ________________

E-Mail: __________________________________________________    Ebola Screened by: __________

Do you suffer from a history of:    In the past 3 months, have you had?
Diabetes            YES  NO    A change in health            YES  NO
High Blood Pressure YES  NO    Nausea/Vomiting            YES  NO
Heart Disease       YES  NO    Fever/Chills/Sweats            YES  NO
Cancer              YES  NO    Unexplained weight change            YES  NO
Seizures            YES  NO    Numbness or tingling            YES  NO
Allergies           YES  NO    Change in appetite            YES  NO
Stroke              YES  NO    Difficulty swallowing            YES  NO
Arthritis           YES  NO    Changes in bowel/bladder            YES  NO
Osteoporosis        YES  NO    Upper respiratory infection            YES  NO
Headaches           YES  NO    Shortness of breath            YES  NO
Pain at night       YES  NO    Dizziness            YES  NO
Asthma              YES  NO    Other            YES  NO

Are you currently pregnant?  YES  NO    If “yes”, when is your due date? ________________

Operations/broken bones/other medical problems: YES  NO
If yes, please list

Are you taking any medications:       YES  NO
If yes, please list
Do you have any allergies:  YES  NO
If yes, please list ________________________________________________
______________________________________________________________

In case of an emergency please notify:
Name: ______________________  DOB: ______________________
Address: _______________________________________________
Relationship to: ______________________  Phone: _____________

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