Capital Health

Outpatient Physiotherapy Referral

☐	Cobequid Community Health Centre	869-6116	Fax: 865-6018
☐	Dartmouth General Hospital	465-8303	Fax: 465-8304
☐	Eastern Shore Memorial Hospital	885-3621	Fax: 885-3210
☐	Hants Community Hospital	792-2071	Fax: 792-2135
☐	Musquodoboit VM Hospital	384-2220	Fax: 384-3310
☐	QEII Health Sciences Centre	473-1288	Fax: 473-3398
☐	Twin Oaks Memorial Hospital	889-4113	Fax: 889-2470

Patient Name: _____

DOB: _____ (YYYY/MM/DD)

Address: _____

_____ Postal Code _____

Phone: (H) _____ (Alt) _____

HCN: _____ (Exp.) _____

Ref. Physician: _____

Family Physician: _____

HUN #: _____ WCB Claim #: _____

PLEASE PRINT

☐ Alt contact: _____ Phone: _____

☐ Interpreter needed - Language: _____

DIAGNOSIS/RELEVANT MEDICAL HISTORY: _____

_____

_____

Tests/Xray Results: _____

☐ Acute onset (0–6 weeks), Date: _____

☐ Exacerbation of chronic condition, Date: _____

☐ Chronic condition

☐ Recent hospitalization: _____

PRECAUTIONS: _____

_____

REASON FOR REFERRAL: _____

_____

_____

☐ **Post-op follow-up** **Surgery date**: _____ **Recheck**: _____

Weight bearing status ☐ NWB ☐ PWB _____ ☐ WBAT

☐ **Recent decline in function**:

☐ Self care ☐ Transfers ☐ Ambulation ☐ Work (last work date) _____

☐ **History of Falls**: Frequency_____/Week _____/Month

☐ **Instruction/Review of exercise program**

☐ **Respiratory issues/Training**: _____

Present mobility status: _____

Home Support/Situation: _____

Referral Source: Name: _____ Designation: _____

(Please print) Signature: _____

Phone: _____ Date: _____