Capital Health

Occupational Therapy Services

Outpatient Occupational Therapy Referral

Patient name _____

Support/Contact person _____ Ph_____

Date of birth: YY _____ MM _____ DD _____

Address: _____

Phone: (Home)_____ (Work)_____

Family physician:_____

Health card #: _____ Exp. date_____

HUN:_____

☐ Cobequid Community Health Centre	869-6116	Fax: 865-6018	WCB Claim #_____
☐ Dartmouth General Hospital	465-8303	Fax: 465-8304	
☐ Eastern Shore Memorial Hospital	885-3619	Fax: 885-3210	
☐ Hants Community Hospital	792-2071	Fax: 792-2135	
☐ Musquodoboit V M Hospital	384-2220	Fax: 384-3310	
☐ QEII Health Sciences Centre	473-4628	Fax: 473-4872	
☐ Twin Oaks Memorial Hospital	889-4102	Fax: 889-2470	
☐ Community Occupational Therapy (Home Visit)	473-2525	Fax: 473-1081	

Date of referral: _____ **Diagnosis/Prognosis:** _____

Pertinent medical history/other health concerns: _____

_____

Relevant surgical intervention/date: _____

_____

REASONS FOR REFERRAL (Check all that apply)

☐ Self care
☐ Work/School
☐ Seating/Wheelchair mobility
☐ Home/Community accessibility
☐ Kitchen safety
☐ Functional transfers
☐ Driving assessment
☐ Splinting assessment
☐ Scar management
☐ Leisure
☐ Upper extremity/Hand therapy
☐ Lymphedema/Edema management
☐ Self-management skills
☐ Community living skills (i.e. banking, shopping, transportation)
☐ Education re: _____
☐ Other:_____

_____

CLIENT'S RISK FACTORS: (Check all that apply)

☐ **FALLS:** Has the client fallen in the last month ☐ Yes ☐ No If yes, how many times? _____

Where? _____

☐ **PRESSURE SORES:** ☐ New ☐ Existing ☐ Stage: Current treatment / Equipment

CURRENT HOME SUPPORTS: ☐ Family ☐ Friend ☐ Lives alone

☐ Home Care (number of hours per week): _____

☐ Private care (number of hours per week): _____

☐ Other: _____

PROFESSIONALS INVOLVED WITH CLIENT: (Please provide names)

☐ Occupational Therapist _____ ☐ Physiotherapist _____

☐ Social Worker _____ ☐ Home Care Worker_____

PHYSICIAN SIGNATURE REQUIRED FOR: Driving Ax, Cardiac Rehab, Acute Pre/Post Surgical Conditions, Acute Post Fracture

REFERRAL SOURCE (Please print): Name: _____

Signature:_____

Phone number: _____