Capital Health

Occupational Therapy Services

Outpatient Occupational Therapy Referral

Patient name _____
Contact person (name) _____
Contact person (Ph) _____
Date of birth: YY _____ MM _____ DD _____
Address: _____
Phone: (H)_____ (W)_____
Family physician:_____
HCN : _____ Exp. date _____
HUN: _____

☐ Cobequid Community Health Centre	869-6116	Fax: 865-6018
☐ Eastern Shore Memorial Hospital	885-3619	Fax: 885-3210
☐ Musquodoboit V M Hospital	384-4108	Fax: 384-3310
☐ QEII Health Sciences Centre	473-4628	Fax: 473-4872
☐ Twin Oaks Memorial Hospital	889-4102	Fax: 889-2470

Date of referral (yyyy/mm/dd): _____ Diagnosis/Prognosis: _____

_____

_____

Relevant surgical intervention/date: _____

_____

Other relevant health concerns: _____

REASONS FOR REFERRAL _____

_____

_____

_____

(Check all that apply)

☐ Upper extremity Management
☐ Splinting assessment
☐ Self care / Self management skills
☐ Lymphedema
☐ Education re: _____
☐ Functional transfers
☐ Seating/Wheelchair mobility
☐ Kitchen safety
☐ Home/Community Accessibility
☐ Work/School for ABI
☐ Post ABI education
☐ Community living skills
(i.e. banking,shopping, transportation)

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

☐ **Falls:** Frequency and number of falls _____ How recently? _____
Location of falls_____

☐ **Skin integrity concerns or pressure sores:** Please elaborate: _____

☐ New ☐ Existing ☐ Stage: _____ Current treatment /Equipment _____

☐ **Pain:** Please elaborate: _____

☐ **Client living in unsafe situation:** Please explain: _____

PHYSICIAN SIGNATURE REQUIRED FOR: Acute Pre/Post Surgical Conditions, Acute Post Fracture

REFERRAL SOURCE (Please print): Name: _____
Signature: _____
Phone number: _____