Occupational Therapy Services

OUTPATIENT OCCUPATIONAL THERAPY REFERRAL

❑ Cobequid Community Health Centre 902−869−6116 Fax: 902−865−6018

❑ QEII Health Science Centre 902−473−4628 Fax: 902−473−4872

Date of referral (YYYY−MM−DD): _____

Diagnosis/Prognosis: _____

_____

_____

Relevant surgical intervention/date (YYYY−MM−DD): _____

_____

Other relevant health concerns: _____

REASONS FOR REFERRAL: _____

_____

_____

_____

(Check all that apply)

❑ Upper extremity management ❑ Functional transfers

❑ Splinting assessment ❑ Seating/Wheelchar mobility ❑ Post ABI education

❑ Self care / Self management skills ❑ Kitchen safety ❑ Community living skills

❑ Lymphedema ❑ Home/Community Accessibility (i.e. banking, shopping, transportation)

❑ Work/School for ABI−Expected return date (YYYY−MM−DD): _____

❑ Education re: _____

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: _____