Occupational Therapy Services
OUTPATIENT OCCUPATIONAL THERAPY REFERRAL

QEII Health Science Centre: Phone: 902-473-4628 Fax: 902-473-4872

Date of referral (YYYY/MON/DD): ____________________

Diagnosis/prognosis: ____________________

Relevant surgical intervention/date (YYYY/MON/DD): ____________________

Other relevant health concerns: ____________________

REASONS FOR REFERRAL: ____________________

(Check all that apply)

- ❑ Upper extremity management
- ❑ Splinting assessment
- ❑ Self care/Self management skills
- ❑ Lymphedema
- ❑ Functional transfers
- ❑ Seating/Wheelchair mobility
- ❑ Kitchen safety
- ❑ Home/Community Accessibility
- ❑ Post acquired brain injury (ABI) education
- ❑ Community living skills (i.e. banking, shopping, transportation)
- ❑ Work/School for ABI-Expected return date (YYYY/MON/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: Name *(please print)*: ____________________

Signature: ____________________

Phone number: ____________________