Capital Health

Community Referral

Client name: ____________________

Date of birth: (YY/MM/DD) ____________
Address ____________________
____
Phone: ____________________
HCN# ____________________

☐ **Occupational Therapy (Home visit)**
Phone: 487-0622 Fax: 454-1477

☐ **Physiotherapy (Home visit)**
Phone: 487-0622 Fax: 454-1477

HEALTH INFORMATION

Diagnosis/Relevant Medical History ____________________
____
____

☐ Palliative
☐ Recent surgery ____________________
☐ Weight bearing status ____________________
☐ Recent history of falls (frequency) ____________________
☐ Mental health issues ____________________
Mobility ____________________
Other information ____________________

REASON FOR REFERRAL (Check all that apply)

OCCUPATIONAL THERAPY

☐ Self care (washing, dressing, toileting)
☐ Seating / wheelchair mobility
☐ Home / community accessibility
☐ Meal preparation
☐ Functional transfers
☐ Pressure sores new existing stage ________
☐ Other ____________________

PHYSIOTHERAPY

☐ Post-op follow-up
☐ Recent decline in mobility
☐ Deconditioned
☐ Review of exercise program
☐ Caregiver training
☐ Respiratory issues / training

CURRENT HOME SUPPORTS : ☐ Family ☐ Friend ☐ Lives alone
☐ Home care (hours/week) ______ ☐ Private care (hours/week) ______ ☐ Assisted Living
Is client aware of referral? ☐ Yes ☐ No
Person to contact to book appointment:
☐ Client ☐ Support (name/phone) ____________________ ____________________

REFERRAL SOURCE (Please Print): Name: ____________________
Designation: ____________________
Signature: ____________________
Phone number: ____________________ Date: ____________________

Referral Forms