Capital Health

Community Referral

☐ 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:__________________