Capital Health

Occupational Therapy Services

Outpatient Self Referral

Patient Name: ____________________

Date of Birth: Year ______ Month _____ Day _____

Address: ____________________

Phone No: (H) ____________ (W) ____________

Family Physician: ____________________

Health Card No: __________ (Expiry date) _______

Date of Referral: ____________________

What are your present health concerns/diagnosis? ____________________

General Health Information: (check all that apply)

☐ Infections	☐ Joint Replacement	☐ History of Seizure
☐ High Blood Pressure	☐ Cancer	☐ Shortness of Breath
☐ Heart Problems	☐ Osteoporosis	☐ Diabetes
☐ Circulatory Problems	☐ Pregnancy (# of weeks ____)	☐ Lung Disease

☐ Other ____________________

Date of most recent hospitalization: ____________ Reason: ____________________

How do you feel an Occupational Therapist can help you? ____________________

Are you presently seeing another Health Care Professional? (Check all that apply)

☐ Occupational Therapist ☐ Physiotherapist ☐ Social Worker ☐ Nurse ☐ Massage Therapist
☐ Psychologist ☐ Other ____________________

Do the concerns you have identified affect your daily activities? ☐ Yes ☐ No

If yes, do the concerns affect your ability to: (Check all that apply)

☐ Take care of yourself ☐ Take care of others ☐ Work ☐ Leisure

What are your current supports at home? (Check all that apply)

☐ Family ☐ Friend ☐ Lives Alone
☐ Homecare (number of hours per week): ____________________
☐ Private Care (number of hours per week): ____________________
☐ Other ____________________

What equipment do you have to assist with daily activity? (Check all that apply)

☐ Walking Aides ☐ Wheelchair ☐ Bathroom Equipment ☐ Splints
☐ Other ____________________

Have you fallen in the last month? ☐ Yes ☐ No

If yes, how many times? ____________ and where? ____________________

Do you feel you can manage safely for the next month in your current condition?

☐ Yes ☐ No

PLEASE COMPLETE REVERSE SIDE

Consent for Release of Information

I ______________________________________ hereby give the Capital Health, Occupational Therapy Department permission to contact my family doctor ____
(name)
to discuss my condition and general health.

I ____ hereby give the Capital Health, Occupational Therapy Department permission to release information about my initial assessment and progress in occupational therapy to my family doctor ____.
(name)

Signature: ____________________________ Date: __________________

Signature of witness: ____________________________ Date: __________________

Please return Referral to: **or**

Queen Elizabeth II Health Sciences Centre
Halifax Infirmary Site
Occupational Therapy Department Room 4838
1796 Summer Street
Halifax, NS B3H 3A7