Community Occupational Therapy and Physiotherapy

REFERRAL FORM

❑ **Occupational Therapy** ❑ **Physiotherapy** **Fax to:** _____
(Refer to fax numbers on back of form)

Client Name: _____ **Date of Birth** (YYYY/MON/DD): _____

Address: _____

Phone Number: _____ **Health Card #:** _____

Family Doctor: _____

HEALTH INFORMATION:

Diagnosis / Relevant Medical History: _____

_____

❑ Palliative (end of life care): _____
❑ Precautions / Recent Surgery: _____
❑ Weight bearing status: _____
❑ Recent history of falls (frequency): _____
❑ Cognitive / Mental Health status: _____

REASON FOR REFERRAL (Check all that apply):

CLIENT / FAMILY GOAL(S): _____

❑ Personal care (washing, dressing, toileting, feeding)
❑ Transfers (bed, chair, toilet, bath)
❑ Recent decline in mobility and / or transfers
❑ Home / community accessibility
❑ IADL (e.g. meal prep, household management)
❑ Pressure injury ❑ New ❑ Existing ❑ Prevention
❑ Family / friend caregiver support and training
❑ Post−op follow−up
❑ Seating / wheelchair mobility
❑ Respiratory issues
❑ Deconditioned
❑ Home exercise program
❑ Other: _____

CURRENT HOME SUPPORTS: ❑ Family ❑ Friend ❑ Lives alone ❑ Assisted Living

❑ Continuing Care / Home Supports (hrs. / week): _____ ❑ Private care (hrs. / week): _____

❑ Continuing Care Nursing or VON Support (hrs. / week): _____

Other health professionals / agencies involved (i.e. VAC, WCB, private practitioner, educational institution):

_____

Consent for referral: ❑ Client ❑ Substitute Decision Maker (SDM) or Enduring Power of Attorney (EPOA)

Person to contact to book appointment:

❑ Client ❑ Support Person: _____
(name) (phone)

REFERRAL SOURCE:

Name / Designation: _____ Signature: _____
(please print)

Phone number: _____ Date (YYYY/MON/DD): _____

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PRE−VISIT RISK IDENTIFICATION / WORKER SAFETY	
❑ Yes ❑ No	To your knowledge, is there any reason a home visit to this client may pose a risk to staff?
❑ Yes ❑ No	Does client have any pets? If so, client has been informed to secure pet in another room when staff visit.
❑ Yes ❑ No	Does client live alone?
❑ Yes ❑ No	Will others be present if a care provider is there? If so, provide details: _____
❑ Yes ❑ No	Does client have any guns or other weapons in the home?
❑ Yes ❑ No	If so, client has been informed to keep them locked?
❑ Yes ❑ No	Does client or others in the home smoke?
❑ Yes ❑ No	Client has been informed to refrain from smoking 60 minutes before and during visits.

Please attach relevant completed Safety Risk Assessment information.

Central Zone	❑ HRM, West Hants, Eastern Shore	Fax: 902−454−1477
Eastern Zone	❑ Guysborough, Antigonish, Strait	Fax: 902−863−7347
	❑ All other areas Cape Breton Island	Fax: 902−567−7986
Northern Zone	❑ Colchester East Hants	Fax: 902−895−3572
	❑ Colchester East Hants Home First	Fax: 902−893−5604
	❑ Cumberland County	Fax: 902−667−6389
	❑ Pictou County	Fax: 902−755−2128
Western Zone	❑ Annapolis Community Health Centre, Annapolis Royal	Fax: 902−532−0977
	❑ Digby General Hospital	Fax: 902−245−3000
	❑ Lunenburg County	Fax: 902−543−1887
	❑ Queens County	Fax: 902−354−7162
	❑ Roseway Hospital, Shelburne	Fax: 902−875−2911
	❑ Soldiers Memorial Hospital, Middleton	Fax: 902−825−1282
	❑ Valley Regional Hospital, Kentville	Fax: 902−679−2499
	❑ Yarmouth Regional Hospital	Fax: 902−749−0759