Occupational Therapy

VOCATIONAL OUTPATIENT SERVICES REFERRAL FORM

Fax to: 902–473–1384

Department use only: Date Received: ____________________ (YYYY/MON/DD) Priority: ❑ High ❑ Medium ❑ Low

Referral Type: ❑ Inpatient: __________________ (Services) D/C date: __________________ (YYYY/MON/DD) ❑ Outpatient: __________________ (Services)

Diagnosis / Relevant Medical Information (including date (YYYY/MON/DD) of injury / illness)

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Cause of injury: ❑ Workplace ❑ MVA ❑ Fall ❑ Assault ❑ Medical Event / Condition

❑ Other: ____

Funding: ❑ LTD ❑ CPP ❑ Income Assistance ❑ WCB Policy #: ____________________

❑ Other: ____

❑ If known, please include end date for current funding source (YYYY/MON/DD): ____________________

Reason for Referral: ____

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Client's Occupation: ____

Work Duties: ____

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Education: ❑ Less than secondary ❑ Post–secondary ❑ Community College

❑ University ❑ Other: ______________________________

Education Goal / Objective: ____

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Expected date for return to work / school (YYYY/MON/DD): ______________________________

Driver's License: ❑ Yes ❑ No **License Classification:** ______________________________

Disciplines Involved: ❑ Occupational Therapy ❑ Physiotherapy ❑ SLP ❑ Psychology

❑ Neuropsychology ❑ Social Work ❑ Physiatry

❑ Other: ______________________________

Referral Source:

Name (please print): ______________________________ Position: ______________________________

Telephone: ______________________________ Fax: ______________________________

Signature: ____

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