Rehabilitation Services
PHYSIOTHERAPY & OCCUPATIONAL THERAPY SELF REFERRAL

Name: _____ Hospital #_____

Address:_____ Health Care #:_____

_____ Parent/Guardian_____

_____ Family Doctor _____

Phone # (Home)_____ D.O.B _____
(MM/DD/YYYY)

(Work) _____

Occupation: _____ ☐ Male ☐ Female

Describe your problem:_____

_____

Check as following applies to you:

☐ Pain disturbing sleep ☐ Off work because of problem

☐ Medication helps ☐ Medication does not help

☐ Unable to do normal activities ☐ Unable to do sports / hobbies

☐ Had therapy in past for same problem

☐ Saw someone else for this problem
Explain:_____

Thank you for your co−operation. You will be on a waiting list for treatment. The urgency of your problems will help us decide when to call you with an appointment. You have the right to see a doctor for your problem while on our waiting list.

_____ _____
Date **Client Signature**

☐ I give permission for the therapist to obtain/ release information to my family physician.

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