Adaptive Care Solutions
OCCUPATIONAL THERAPY
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OCCUPATIONAL THERAPY REFERRAL FORM

CLIENT INFORMATION

Client Name: _____ **Date of Birth:** _____
Address: _____ **PHIN:** _____
City / Postal Code: _____ **Phone:** _____
Email: _____ **Preferred Contact Method:** _____
Emergency Contact: _____ **Relationship / Phone:** _____

REFERRAL SOURCE

Referring Physician / Provider: _____ **College / Licence #:** _____
Clinic / Facility Name: _____ **Fax:** _____
Phone: _____ **Date of Referral:** _____

APPOINTMENT TYPE REQUESTED

☐ Comprehensive Functional Home Assessment	☐ Functional Mobility and Transfer Assessment
☐ Wheelchair Seating Assessment	☐ Cognitive Assessment
☐ Initial Occupational Therapy Assessment	☐ Follow-Up Assessment

FUNDING / PAYER SOURCE

☐ Private Pay ☐ MPI ☐ WCB ☐ Veterans Affairs Canada ☐ Extended Health Benefits ☐ Other: _____

PRIORITY

☐ Routine ☐ Urgent ☐ Post-Discharge (within 2 weeks)

REASON FOR REFERRAL / PRESENTING CONCERNS

RELEVANT DIAGNOSIS / MEDICAL HISTORY

CURRENT EQUIPMENT IN USE (MOBILITY AIDS, SEATING, HOME MODIFICATIONS, ETC.)

PRECAUTIONS / CONTRAINDICATIONS

☐ Fall Risk ☐ Cardiac Precautions ☐ Weight-Bearing Restrictions
☐ Cognitive Impairment ☐ Behavioural Concerns ☐ Isolation Precautions

ADDITIONAL NOTES

REFERRER AUTHORIZATION

I confirm that the above client has consented to this referral and to the release of relevant health information to Adaptive Care Solutions for the purpose of occupational therapy assessment and treatment.

_____ _____
Referrer Signature *Date*

FOR OFFICE USE ONLY
Date Received: _____ **Assigned Therapist:** _____ **Appt. Booked:** _____