Cris A. Rowan BScOT, BScBi
Registered Occupational Therapist
Paediatrics, Geriatrics & Ergonomics

OCCUPATIONAL THERAPY **REFERRAL** FORM

Date: _____ Request is: **Urgent** _____ **Routine** _____

Name: _____ DOB: _____

Address: _____ Phone: (H) _____ (W) _____

Family Physician: _____ Phone: _____

Referral Information:

Name: _____ Agency: _____

Address: _____ Phone: _____

Specialists Involved:

_____

_____

_____

Support Personnel Involved (e.g. physiotherapy, massage, chiropractic):

_____

_____

_____

Diagnosis of Illness or Injury:

_____

_____

Pertinent Medical History:

_____

_____

_____

Reason for Referral (be specific):

_____

_____

_____

_____

Are any of the following areas of concern? If yes, please expand.

- Feeding (choking) Yes ( ) No ( ) _____
- Mobility (wheelchair, walking) Yes ( ) No ( ) _____
- Equipment (walker, splints) Yes ( ) No ( ) _____
- Transfers (bath tub, toilet, floor) Yes ( ) No ( ) _____
- Self care (dressing, bathing, toileting) Yes ( ) No ( ) _____
- Pain Yes ( ) No ( ) _____

6840 Seaview, Sechelt, BC V0N 3A4 • *email:* crowan@suncoastot.com • *website:* **www.suncoastot.com** • *Tel:* 604-885-0986 • *Fax:* 604-885-0389 • *Cell:* 604-740-2264

Occupational Performance Concerns:

Attention: Yes ( ) No ( ) _____

Organization: Yes ( ) No ( ) _____

Follows directions: Yes ( ) No ( ) _____

Learns new skills: Yes ( ) No ( ) _____

Directionality and spatial concepts: Yes ( ) No ( ) _____

Vision: Yes ( ) No ( ) _____

Hearing: Yes ( ) No ( ) _____

Social Skills: Yes ( ) No ( )_____

Additional Comments:

_____

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