



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 () _____

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:
