STANTON REGIONAL HOSPITAL

REHABILITATION DEPARTMENT
REFERRAL FOR OCCUPATIONAL THERAPY/
PHYSIOTHERAPY

TABLED DOCUMENT 79-17(3)
TABLED ON OCTOBER 25, 2012

☐ Physiotherapy ☐ Pediatric Physiotherapy

☐ Occupational Therapy ☐ Pediatric Occupational Therapy

NAME:_____ D.O.B:_____ THIS#_____

ADDRESS:_____ PHONE:_____ (H) _____(W)

DIAGNOSIS/HISTORY:_____

TREATMENT:_____

☐ ROUTINE ☐ URGENT

URGENT CLIENTS MUST MEET ONE OR MORE OF THE CRITERIA BELOW. PLEASE CHECK OFF ALL THAT APPLY.

☐ WCB Referral ☐ Unable to work due to this problem

☐ Post-op orthopaedic surgery ☐ Post cast removal

☐ Unable to manage safely at home ☐ Neurological or discogenic signs

☐ **I authorize the purchase of necessary equipment/medical supplies**

Clinic Stamp Required in Box

Physician Name (Please Print)

Physician Signature

Date

SYH # 6873-108-02