Community Occupational Therapy and Physiotherapy
REFERRAL FORM

❑ **Occupational Therapy** ❑ **Physiotherapy** **Fax to:** _____
(Refer to fax numbers on back of form)

Client Name: _____ **Date of Birth** (YYYY/MON/DD): _____

Address: _____

Phone Number: _____ **Health Card #:** _____

Primary Health Care Provider: _____

HEALTH INFORMATION:

Diagnosis/Relevant medical history: _____

_____

_____

_____

❑ Palliative (end of life care): _____ ❑ Recent history of falls (frequency): _____

❑ Precautions/Recent surgery: _____ ❑ Weight bearing status: _____

❑ Cognitive/Mental health status: _____

Admission Status: _____ Hospital: _____ Estimated Discharge Date: _____
(YYYY/MON/DD)

REASON FOR REFERRAL (Check all that apply):

CLIENT/FAMILY GOAL(S): _____

❑ Personal care (washing, dressing, toileting, feeding)
❑ Transfers (bed, chair, toilet, bath)
❑ Recent decline in mobility and/or transfers
❑ Home/Community accessibility
❑ IADL (e.g. meal prep, household management)
❑ Pressure injury ❑ New ❑ Existing ❑ Prevention
❑ Family/friend caregiver support and training
❑ Post-op follow-up
❑ Seating/Wheelchair mobility
❑ Respiratory issues
❑ Deconditioned
❑ Home exercise program
❑ Other: _____

CURRENT HOME SUPPORTS: ❑ Family ❑ Friend ❑ Lives alone ❑ Assisted Living

❑ Continuing Care/Home Supports (hours/week): _____ ❑ Private care (hours/week): _____

❑ Continuing Care Nursing or VON Support (hours/week): _____

Other health professionals/agencies involved (i.e. VAC, WCB, private practitioner, educational institution):

_____

Consent for referral: ❑ Client ❑ Substitute Decision Maker (SDM) or Enduring Power of Attorney (EPOA)

Person to contact to book appointment:

❑ Client ❑ Support Person: Name: _____ Phone #: _____

REFERRAL SOURCE:

Name/Designation: _____ Signature: _____
(please print)

Phone number: _____ Fax number: _____ Date: _____
(YYYY/MON/DD)

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PRE-VISIT RISK IDENTIFICATION/WORKER SAFETY

- ❑ Yes ❑ No To your knowledge, is there any reason a home visit to this client may pose a risk to staff?
- ❑ Yes ❑ No Does client have any pets? If so, client has been informed to secure pet in another room when staff visit.
- ❑ Yes ❑ No Does client live alone?
- ❑ Yes ❑ No Will others be present if a care provider is there? If so, provide details: _____
- ❑ Yes ❑ No Does client have any guns or other weapons in the home?
- ❑ Yes ❑ No If so, client has been informed to keep them locked?
- ❑ Yes ❑ No Does client or others in the home smoke?
- ❑ Yes ❑ No Client has been informed to refrain from smoking 60 minutes before and during visits.

Please attach relevant completed Safety Risk Assessment information.

Central Zone	❑ HRM, West Hants, Eastern Shore	Fax: 902-454-1477
Eastern Zone	❑ Guysborough, Antigonish, Strait	Fax: 902-863-7347
	❑ All other areas Cape Breton Island	Fax: 902-567-7986
Northern Zone	❑ Colchester East Hants	Fax: 902-895-3572
	❑ Colchester East Hants Home First	Fax: 902-893-5604
	❑ Cumberland County	Fax: 902-667-6389
	❑ Pictou County	Fax: 902-755-2128
Western Zone	❑ Annapolis Community Health Centre, Annapolis Royal	Fax: 902-532-0977
	❑ Digby General Hospital	Fax: 902-245-3000
	❑ Lunenburg County	Fax: 902-543-1887
	❑ Queens County	Fax: 902-354-7162
	❑ Roseway Hospital, Shelburne	Fax: 902-875-2911
	❑ Soldiers Memorial Hospital, Middleton	Fax: 902-825-1282
	❑ Valley Regional Hospital, Kentville	Fax: 902-679-2499
	❑ Yarmouth Regional Hospital	Fax: 902-749-0759