



Affix Label Here

Outpatient Therapy Referral

*Occupational Therapy

*Physiotherapy

Day Programs: Inflammatory Arthritis OA

NOTE: Day programs involve intensive multidisciplinary rehab, requiring attendance from 9:00 - 4:00 Monday to Friday for 2 weeks.

Telephone Home: _____ Work: _____

Diagnosis: _____

DateOf Onset: _____

Reason for Referral: _____

Status: Acute Subacute Chronic WSIB

Other Medical Conditions: _____

OperativeProcedure(s) and Date(s): _____

Investigative Procedures (x-rays, EMG, lab work, etc.): _____

cc Physio/OT clinic note

Date: _____

Signature of Physician

Please print name

*Patient will be assessed and treated by the appropriate discipline or cross-referred where indicated.

THERAPIST USE ONLY Cross Referral to OT <input type="checkbox"/> PT <input type="checkbox"/> Reason for Referral: _____ Treatment provided to date: _____ _____ Is patient still actively being treated?: Yes <input type="checkbox"/> No <input type="checkbox"/> Date: _____ Therapist: _____	
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