

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

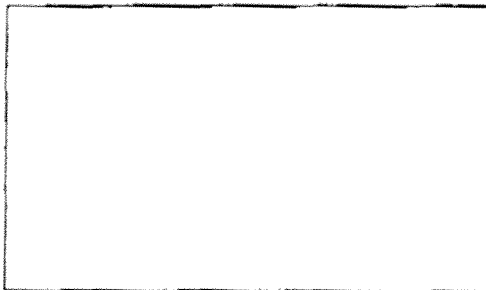
NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_ THIS# \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_ (H) \_\_\_\_\_ (W)  
DIAGNOSIS/HISTORY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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