

905-873-4598 905-876-7022 905-845-9540 (Work-Fit)

Name:	_
D.O.B	
Health Card:	

## **Outpatient**

## **Rehabilitation Services Referral**

## **Hand Therapy Program**

Weight Bearing Status:

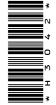
## **Work-Fit Total Therapy**

D.O.B
Health Card:
Telephone: (Home)
(Work):

☐ OT/PT Combined		☐ Physiotherapy Pro	ogram (PT)	(Cell):		
Outpatient	☐ Inpatient (	Entered in Order Entry)		□ Urgent	□ W.S.I.B.	
REFERRING DIAGNOSIS:						_
SPECIAL INSTRUCTIONS:						_
						_
TREATMENT GOALS:						
						_
			1			
Date of Onset of Injury / Pr	ocedure:		Referral Criteria:	_		
				Recent Surge	•	
				☐ Acute Condit	ions: 6 weeks or less	
♦ Have X-Rays Been Taken? ☐ No ☐ Yes – If not at Halton Healthcare, please have patient provide CD of x-rays						

☐ None ☐ Partial ☐ Full ☐ Increase as Tolerated

Physician's Signature:	Date:	NEXT APPOINTMENT WITH PHYSICIAN:					
Physician's Name (Print):							
Fracture Bracing Delegation Accepted by:							
Office Use Only  Date Referral Received:							
Attempts to Contact Patient: Date	Time	Clerk					
Date	Time	Clerk					
Treatment Given:							



		Patient/SDM consent to the assessment and treatment plan, the nature of which has been explained to him/her. He/she understands the risks, benefits and consequences of refusing recommended treatment.
Αрр	ointm	nent Booking:

If sending by FAX: GH: 905-873-4567 MDH: 905-876-7005 OTMH: 905-815-5109