Kootenay Kids
804 Stanley Street
Nelson, BC V1L 1N7
Phone: 250-505-1171
Fax: 250-505-1172

Physiotherapy & Occupational Therapy Program

REFERRAL FORM

Physiotherapy ( ) Occupational Therapy ( )

Referral date_____ Age at Referral_____

FAMILY INFORMATION

Child's Name: _____D.O.B._____ Gender: _____
Parent/Caregiver: _____Phone: _____Work:_____
Cell: _____ Email: *_____
Parent/Caregiver: _____Phone: _____Work:_____
Cell: _____ Email:* _____

( ) *Yes I understand and accept the risks of sending confidential information (such as reports specific to my child) by e-mail.

Custody _____
Siblings: (name(s) and age) _____
Mailing Address_____ Postal code_____
Street Address_____
Directions to Home: _____
Safety Information: _____
Cultural Factors such as Aboriginal Heritage/First Language_____

REFERRAL INFORMATION

Referral Source: _____Phone/Fax: _____ Email: _____
Birth Info: Hospital: _____ APGARS_____ Birth weight_____
Gestational Age: _____ Physician: _____

Reason for Referral *and other pertinent data: (diagnosis, needs, medications)* _____
_____
_____
_____

OTHERS INVOLVED *Please include Daycare and Days/Hours attending*

Name/Agency	Phone/Fax	Reports included

I have read the information above, it is correct and I agree to service.

Parent signature: _____ **Date** _____

OFFICE USE ONLY:

Received_____ Date onto Caseload_____ Age_____ LOT on WL_____

- o Contacted referral source
- o Entered into Access
- o Informed of estimated WL
- o Contacted within one week_____ #2 _____ #3 _____

Referred out_____ Ineligible_____ D/C date_____