PHYSIOTHERAPY & OCCUPATIONAL THERAPY PROGRAM
804 Stanley St. Nelson BC V1L 1N7 Tel. 250-505-1171 ext. 5 Fax 250-505-1172

REFERRAL FORM

Forms can be faxed to 250-505-1172 or emailed to therapyservices@kootenaykids.ca
You will receive a confirmation phone call within 1 week of sending referral

REFERRAL FOR: **Physiotherapy** ☐ **Occupational Therapy** ☐ **Referral Date:**

Child's Name: _____D.O.B._____ Gender: _____
Cultural Factors such as Aboriginal Heritage/Other Language spoken at home _____
Allergies/Medications:

FAMILY INFORMATION

Parent/Caregiver(s): _____ _____
Legal Guardian name (if different from parent/caregiver): _____
Preferred contact method: Phone ☐ Text ☐ Email ☐
Phone(s): _____ _____
Email(s): *_____ _____

☐ ***I understand and accept the risks of sending confidential information (such as reports) by e-mail***

VISIT INFORMATION

Street Address: _____
Any particular instructions to find home: _____
Best days to organize visits: _____
Any safety considerations for staff (e.g. big dog, smoking): _____

REFERRAL INFORMATION

Referral Source: _____Phone/Fax: _____Email: _____
How did you hear about us?
Child's Relevant History:

Family's Main Concerns:

OTHERS INVOLVED

Services: *(e.g. SCD, SLP):* _____
Physician: _____

Name of Childcare Centre (if attending) :	Contact Person and Phone Number:	Days/Hours that child attends:

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

Parent signature: _____ **Date** _____

OFFICE USE ONLY:

○ Contacted referral source	○ Entered into Access	○ Informed of estimated WL
○ Received_____	○ Date onto Caseload_____	○ LOT on WL_____
○ Contacted #1_____	○ #2_____	○ #3_____
○ Referred out_____	○ Ineligible_____	○ D/C date_____