Referral for Therapies – PAPHR
Victoria Hospital

PHONE: 765-6126
FAX: 765-6284

☒ PHYSICAL THERAPY
☐ OCCUPATIONAL THERAPY
☐ SPEECH & LANGUAGE – ADULTS
☐ SPEECH & LANGUAGE - PRESCHOOLERS
☐ HOME CARE:OT ___ PT ___ Aquacise ___
☐ PEDIATRIC EARLY DEVELOPMENT SERVICES TEAM

*Please attach x-ray, MRI, CT scan reports if appropriate

TO BE COMPLETED BY PHYSICIAN/NP:
(Please write legibly or your referral will be returned)

DATE OF REFERRAL:

DIAGNOSIS / REASON FOR REFERRAL:

School-based PT - John de Padua

PLEASE CHECK ONE OF THE FOLLOWING:

___Acute (0 – 6 weeks)
___Subacute (6 weeks to 3 months)
___Chronic (3 months and up)

CONTRAINDICATIONS / PRECAUTIONS / COMMENTS:

GOALS OF REFERRAL:

DR/N.P NAME (PRINTED): ____________________

DR/N.P(SIGNATURE):____________________

Order # 131310

NAME:____________________

(Legal Guardian's name if child)____________________

PHONE home __________ work__________
cell __________ message__________

ADDRESS____________________

HSN.__________ Postal Code:__________

DOB__________ Unit #__________

BAND & TREATY #____________________

FAMILY PHYSICIAN____________________

TO BE COMPLETED BY CLIENT	YES	NO
Is this injury covered by ☐ SGI, ☐ WCB (If yes-please refer to a private Physiotherapy practice)		
Are you pregnant?		
Have you had cancer in your past or present?		
Do you have a pacemaker?		
Are you on any heart or blood pressure medication?		
Are you on any blood thinners?		
Do you have any blood disorders?		
Have you had any surgery in the past 5 years?		
Do you have a history of seizures?		
Have you had a fall in the past year?		
Do you receive Home care Services?		
Are you experiencing any depression? If Yes please complete back of this page.		
Do you have other medical insurance? (Blue Cross, DVA, MSI,etc)		
I give consent for the Therapist (s) to obtain report (s) or information from my doctor (s) or other health care professional (s) that may be useful to my therapy assessment and/or treatment.		

I agree to have an assessment and treatment by a male or female Therapist which may involve:

- **Disrobing,**
- **Manual palpation (touching, moving of body parts),**
- **Visual examination of body part (s) and body movement (s).**

I understand that I have the right to refuse any part of the assessment and treatment (s) and that I am responsible for informing the Therapist (s) of this decision. Not doing so will indicate that I am in agreement with the assessment/treatment. I will give 24 hours notice to cancel or change an appointment.

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CLIENT'S / LEGAL GUARDIAN'S SIGNATURE