Halton Healthcare

Georgetown Hospital **905-873-4598**
Milton District Hospital **905-876-7022**
Oakville Trafalgar Memorial Hospital **905-338-4613 (Hand Therapy)**
905-845-9540 (Work-Fit)

Name: _____

D.O.B _____

Health Card: _____

Telephone: (Home) _____

(Work): _____

(Cell): _____

Outpatient Rehabilitation Services Referral

Hand Therapy Program

❒ **Occupational Therapy (OT) Only**
❒ **OT/PT Combined**

Work-Fit Total Therapy Centre

❒ **Physiotherapy Program (PT)**

❒ Outpatient ❒ Inpatient (Entered in Order Entry) ❒ Urgent ❒ W.S.I.B.

REFERRING DIAGNOSIS: _____

SPECIAL INSTRUCTIONS: _____ _____

_____

TREATMENT GOALS: _____

_____

Date of Onset of Injury / Procedure:

_____

Referral Criteria:

❒ Recent Surgery/Fracture
❒ Acute Conditions: 6 weeks or less

♦ Have X-Rays Been Taken? ❒ No ❒ Yes – If not at Halton Healthcare, please have patient provide CD of x-rays

♦ Weight Bearing Status: ❒ None ❒ Partial ❒ Full ❒ Increase as Tolerated

Physician's Signature: _____ Date: _____

Physician's Name (Print): _____

Fracture Bracing Delegation Accepted by: _____

NEXT APPOINTMENT WITH PHYSICIAN:

_____

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.

Appointment Booking:

_____

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