

Hand Therapy Clinic

Outpatient Rehabilitation Referral Form

1 Hospital Drive Peterborough, ON K9J 7C6

t: 705-743-2121 x. 2828 | f: 705-876-5840

PATIENT LABEL

Please ensure that the referral is fully completed and supporting documents attached before faxing to the department.

Date of referral (DD/MM/YYYY): _____

Patient Name:	Date of Birth (DD/MM/YYYY):	Health Card #:
Address:	TELEPHONE Home: _____ Work: _____ Cell: _____	
Diagnosis:	Date of Onset	
Surgical Procedure:	Date of Surgery	
Is this referral for post-op physiotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Reason for referral: <input type="checkbox"/> Hand Therapy <input type="checkbox"/> Hand Splint		
<input type="checkbox"/> WSIB: Claim Number: _____		Date of Accident: _____
Employer: _____		Address: _____
Employer Phone: _____		Employer Fax: _____
Restrictions/ Protocols /Splinting Information:		
Health History/Precautions: <input type="checkbox"/> Arthritis <input type="checkbox"/> Diabetes <input type="checkbox"/> Dyslipidemia <input type="checkbox"/> Other: _____ <input type="checkbox"/> Allergies <input type="checkbox"/> COPD/Asthma <input type="checkbox"/> Epilepsy _____ <input type="checkbox"/> Cancer: _____ <input type="checkbox"/> HTN <input type="checkbox"/> Liver Disease _____		
Practitioner's Name (please print):		Practitioner's Telephone:
I verify that the above-named patient is appropriate for Hand Therapy Signature of Referring Practitioner:		Date (DD/MM/YYYY):

FOR OFFICE USE:

K# _____ Account # _____ Initials _____

P1 P2 Ax Time 60 90 Other: _____