



Occupational Therapy Services

Referral Form

This form is available to physician's and other health professionals who would like to facilitate a referral for a family. Please note that a family is also able to self-refer to our Occupational Therapy Services.

Child's Name: _____
Date of birth: _____
Diagnosis (if applicable): _____
Parent's Name: _____
Address: _____
Telephone No: _____

Reason for Referral:

<input type="checkbox"/> Pencil grasp	<input type="checkbox"/> Visual Perceptual	<input type="checkbox"/> Fine motor
<input type="checkbox"/> Printing	<input type="checkbox"/> Keyboarding	<input type="checkbox"/> Sensory/Self-regulation
<input type="checkbox"/> Written expression/Organization	<input type="checkbox"/> Other: _____	

Additional Comments:

Home visits At our clinic (Pape & Danforth)

Referral From: _____
Date: _____
Telephone No: _____
Address: _____
Signature: _____

Please Fax to: 1-877-286-9905

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