



Community Therapy
SERVICES

1601 Buffalo Place, Unit/Bureau 101
Winnipeg, MB R3T 3K7
Fax/Telecopieur: 204-942-1428
Phone/Tel.: 204-949-0533

(Addressograph here)

**PERSONAL CARE HOME PROGRAM
OCCUPATIONAL THERAPY
REFERRAL**

Date:

Unit:

Room Number:

Name of Facility:

Name, Designation of Referrer:

Resident and/or POA Aware of Referral? Resident: Yes No POA: Yes No

Relevant Medical History:

Service Request - complete the information below as applicable

Referral will be prioritized at the discretion of the therapist. Priority referrals include: sudden change in mobility and/or transfer status, falls, and/or acute skin integrity concerns.

Clearly outline reason for referral/services requested below.

Multiple empty lines for text entry.

- Date reviewed by OT: _____
- OT Signature: _____
- IPN Complete Date: _____
- File in Consult Section of the Chart