archipelago
REHAB

Occupational Therapy Services Referral Form

Client Information

Name: ______________________ DOB (dd/mm/yyyy): __________________

Email: ______________________ Phone Number: ______________________

Address: ____

Funding Source: Claim / Benefits # (if known): _________________

☐ ICBC ☐ WorkSafe BC ☐ Veterans Affairs ☐ Private Pay ☐ Other

Reason for referral:

☐ Mental Health Services
☐ Home Safety / Mobility
☐ Concussion / Traumatic Brain Injury
☐ Complex pain management
☐ Musculoskeletal / Orthopedic / Post-surgical
☐ Medical Legal
☐ Other

Comments: ____

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Referrer Information

Company / Clinic: ____________________ Name: _________________________

Phone Number: _____________________ Date: ___________________________

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