Referral Form

If you are a health care provider or funder and would like to make a referral you can:

-complete the following referral form and email it to ot@therapyfirst.ca or fax it to 204-669-7114
-contact us by email at ot@therapyfirst.ca for all services except Chronic Pain Support Services where we can be reached at cpss@therapyfirst.ca
-contact us by phone at 204-612-0399

Date: _____

Client Information

Name: _____ DOB: _____

Address: _____

Preferred Phone Number for Contact Person (If different than above): _____

Referred by: ☐ Self ☐ MPI ☐ WCB ☐ Primary Care Provider ☐ Other _____

Name and Contact info for Referral Source: _____

_____

Funding Source: Self ☐ MPI ☐ WCB ☐ Other: _____

Client claim number: _____

Diagnosis and other medical history information _____

_____

_____

_____

Service requested:

☐ Spinal Cord Community Rehabilitation OT ☐ PT ☐ Nursing ☐
☐ Chronic Pain Support Services
☐ Pressure Injury Prevention/Management
☐ Wheelchair and/or Seating Assessment
☐ In Home Functional Assessment (e.g., home safety, accessibility issues)
☐ Upper Extremity Management for Neurological Conditions
☐ Other (please describe): _____

Together We Can!

Spinal Cord Injury Community Care
Wheelchair Seating and Mobility
Home Safety and Accessibility

Web: www.therapyfirst.ca

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