INSPIRE ABILITY

Occupational Therapy Referral Form:

Client Information
Name: _____
Date of Birth: _____
Phone Number: _____
Email Address: _____
Address: _____

Preferred Method of Contact: ☐ Phone ☐ Email ☐ Fax

Referral Source
Referring Individual/Organization: _____

Reason for Referral
Please select the applicable services required:
☐ Mental Health Support
☐ Post-Concussion Rehabilitation
☐ PTSD Support
☐ WorkSafeBC Injury Rehabilitation
☐ ICBC Post-Injury Support
☐ Pediatrics Therapy
☐ Ergonomic Assessments and Recommendations
☐ Home Safety Evaluations
☐ Return-to-Work Support
☐ Virtual Therapy Services
☐ Other (please specify): _____

Client Medical/Health Information
Primary Diagnosis/Condition: _____
History of Relevant Injuries/Conditions: _____
Current Medications: _____
Primary Physician Name: _____
Phone Number: _____

Additional Information

Please submit this form by email or fax.