|  |
| --- |
| Occupational Therapy Referral Form |

## PERSONAL INFORMATION Date: Click or tap to enter a date.

Name: \_\_\_

Date of birth:\_\_\_\_ Age: \_\_\_\_ Grade: \_\_\_\_

Parents/Guardian: \_\_\_\_

Address: \_\_\_\_

Telephone Numbers: Home: \_\_\_\_ Cell (Mother): \_\_\_\_

Cell (Father): \_\_\_\_ Other: \_\_\_\_

Email addresses: \_\_\_\_

School/Day Care: \_\_\_\_

Physician (name, address, & telephone #): \_\_\_\_

## REFERRAL INFORMATION

Primary reason for referral (please be specific): \_\_\_

**Other Services your child is receiving or has received in the past:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Service:** | **Contact Person** | **Phone Number** | **Current?** |
| Special Education | \* | \* | ? |
| Individual Education Assistant | \* | \* | ? |
| Speech Language Pathologist | \* | \* | ? |
| Psychology | \* | \* | ? |
| Occupational Therapy | \* | \* | ? |
| Physiotherapy | \* | \* | ? |
| Other | \* | \* | ? |

Please attach any pertinent clinical reports and/or samples of child’s work.