Physician Referral Form

Please fax to 289-472-5557

Doctors' referrals are not required for service but physicians are welcome to refer directly if patients wish.

REFERRAL DATE (YYYYMMDD):

Patient's Name: DOB (YYYYMMDD):

Address:

Who has legal custody? ☐ Both parents ☐ One parent ☐ Other:

Parent/Guardian email: Parent/Guardian phone number:

Relationship to child if appropriate:

Patients over 18 may wish to be contacted directly. Please provide their contact information if applicable.
Email: Phone:

Are there any diagnoses we should be aware of?
☐ Autism ☐ ADHD ☐ Anxiety ☐ LD ☐ Gifted ☐ Other:

Are there concerns with sensory processing, self-regulation etc. that would benefit from support from our occupational therapist. ☐ yes ☐ no

Reason for referral:

*** Patients' language level should be broadly within an age-expected level due to the friendship-based focus of our work. We do not treat general speech and language delays in our practice.*

☐ Patient is in grade 1 or younger and has difficulty making and/or keeping friends. Parent wants help to support this.

☐ Patient is in grade 2-6 and has trouble making and/or keeping friends, is aware of this and wants some help. Parent is interested in learning how to support.

☐ Patient is in grade 7-12, struggles to connect with others and wants help to address this. Both parent and teen are interested in referral.

☐ Patient is a young adult, struggles with social connection socially at work ,school or in the community, is interested in working with an SLP or OT and is aware of the referral.

Additional comments:

Referring Physician's Information (please stamp or fill in):

Physician name (please print):

Signature:

Phone: