IWK Health Centre
Pediatric Rehabilitation Service

Recreation Therapy Referral

Demographic Information:

Full Name: _____ DOB: _____

Unit #: _____ Next of Kin: _____

Primary Contact to arrange appointments: _____

Relationship to patient: _____ Consent obtained from NOK:_____

Address: _____

Phone: (H) _____ (W) _____ (Cell) _____

School/Preschool: _____

Educational Program Assistant: ☐ Yes ☐ No ☐ F/T ☐ P/T

Reason: _____

School Therapy Services Involved: ☐ Yes ☐ No ☐ OT ☐ PT

Community Therapy Services involved: ☐ Yes ☐ No ☐ OT ☐ PT

COPM Goals: _____

_____

_____

Patient Information:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Known Allergies: _____

Known Medical Considerations: _____

Mobility:

☐ Independent Ambulation
☐ Manual Wheelchair
☐ Power Wheelchair
☐ Walker/Crutches Transfer Ability:

☐ Independent
☐ 1 person assist
☐ 2 person assist

Flight Risk: ☐ Yes ☐ No Behavior Issues Identified: ☐ Yes ☐ No

Describe: _____

_____

Recent admission or surgery:

_____

_____

Referral Source Information:

Referral Name: _____ Profession: _____

Organization: _____

Referral Contact Information: **Phone** _____ **Email** _____

☐ Phone prior to appointment ☐ Schedule Joint appointment

Reason for Referral:

☐ Assistance connecting to home and community recreation resources
☐ Assistance connecting to physical literacy resources, adapted equipment to support outcomes in physical education, participation in school activities (school skates, field trips) and access to playground
☐ Assistance connecting to adapted equipment for home or community play and recreation
☐ Skill Development

Please check one of the following to assist with prioritization:

☐ **There is a participation deadline which requires support to ensure child/youth's timely inclusion.**
☐ **There is a seasonal deadline which requires support to ensure child/youth's leisure**
☐ **Referral is outside the HRM catchment area and awaiting travel dates for multiple referrals unless needs can be met by phone or child/youth is coming to the IWK.**

Comments: _____

Signature: _____ Date: _____

All referrals should be faxed directly to the Administrative Assistant, Pediatric Rehabilitation Service at (902) 470-8348 or email to rehabadminassist@iwk.nshealth.ca

Office Use Only:

Priority: _____ Date: _____

Completed By: _____