LABEL

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Infant & Preschool Rehabilitation Service Referral Form
Physiotherapy (PT) & Occupational Therapy (OT)

Child's full name: ____

DOB (DD/MMM/YYYY): ____________________ MSI Health Card #: ____________________

Parent(s)/ Guardian(s) name(s): ____

Mailing address: ______________________________________ Postal code: __________

Phone number(s): ____

Referred by: ____________________________ Relationship: ______________________

Referral date: __________________ ☐ **Parent/family is aware of and in agreement with this referral**

☐ **I want my child to be able to:**

OR

I would like to talk to a **PHYSIOTHERAPIST** about:

☐ My child's head shape and/or head turning preference

☐ My child's leg/foot position

☐ My child's toe-walking

☐ My child's ability to roll/sit/change position/crawl

☐ My child's ability to stand/walk

☐ My child's ability to climb stairs/jump/run

☐ My child's ability to participate in ball play

☐ My child's ability to participate in outdoor play

I would like to talk to an **OCCUPATIONAL THERAPIST** about:

☐ My child's ability to eat

☐ My child's ability to toilet

☐ My child's ability to dress/bathe

☐ My child's sleep and bedtime routine

☐ My child's behavior during daily activities/ routines

☐ My child's ability to play with toys

☐ My child's ability to draw/ print/ color/ use scissors

Parent/family referrals are encouraged. Please call (902) 470-8025 to discuss whether a referral for PT and/or OT is appropriate.

Referral can be sent by email: preschooltherapy@iwk.nshealth.ca