LABEL

____

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