Therapy First

Therapy First Referral Form

Date: _____

Client Information

Name: _____ DOB: _____

Address: _____

Preferred Phone Number for Contact Person (If different than above): _____

Referred by: ☐ Self ☐ MPI ☐ WCB ☐ Physician (name) _____ ☐ Other_____

Funding Source: Self ☐ MPI ☐ WCB ☐ Other _____

Diagnosis and other medical history information: _____

_____

_____

Service requested:

☐ Wheelchair Seating Assessment
☐ OT Hospital Discharge Assessment
☐ Activities of Daily Living Assessment/Training
☐ Spinal Cord Community Rehabilitation
☐ Personal Care Assessment/Report
☐ Saebo Assessment/Treatment
☐ Environmental Assessment (e.g. home safety, accessibility issues)
☐ Other (please describe): _____

For Office Use Only: Date Client Contacted: _____

If Third Party funding: Funding approval received: Yes ☐ Claim Number: _____

Case Manager: _____ Ph.: _____ E-mail_____

If self funded, fees for services explained ☐ Yes

OT Assigned: _____

Therapy First *Together* **We Can!**
SPINAL CORD & COMMUNITY REHABILITATION, WHEELCHAIR SEATING & MOBILITY, HOME SAFETY & ACCESSIBILITY
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