Acute Care Occupational Therapy Referral Form

Patient Information

Patient Name

Date of Birth

Medical Record Number

Admission Date

Referring Physician

Contact Information

Diagnosis / Reason for Referral

Primary Diagnosis

Additional Diagnosis

Reason for OT Referral

Current Functional Status

Mobility/Transfers

ADLs (Activities of Daily Living)

Cognition/Communication

Precautions & Relevant Medical History

Precautions (e.g. falls, infection, weight bearing)

Relevant Medical History

OT Evaluation Needs

Areas for OT Assessment

Referring Clinician Name

Date of Referral