Spring Occupational Therapy
HAND THERAPY & HOLISTIC HEALTH

1204A Roland Street
Thunder Bay, ON
P7B 5M4

OCCUPATIONAL THERAPY REFERRAL FORM

Patient name:_____Phone: _____

Address: _____

Diagnosis: _____

WSIB claim number: _____

Secondary Diagnosis:_____

Insurance company and claim number: _____

History/Precautions: _____

Physician's Name/

Title:_____Phone:_____

Address:

_____

Please send referral and current history to: Spring Occupational Therapy

☐ EVALUATION and REPORT
☐ OCCUPATIONAL THERAPY EVALUATION AND TREATMENT

Frequency/Duration: _____times weekly for _____weeks

Additional Information:

_____ _____
PHYSICIAN'S SIGNATURE DATE

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