PATIENT NAME: ______________________

DOB: ______________________

HRN: ______________________

HC#: ______________________

ADDRESS: ______________________

PHONE: ______________________

Hand and Upper Extremity Therapy Program (OT/PT) Referral Ambulatory Rehabilitation Clinic

Phone: 705-739-5602
Fax: 705-739-5688

Diagnosis: ______________________

Date of Injury/Surgery: ______________________

Precautions/Contraindications (i.e. tendon integrity, pulley repairs, tension):

____

____

____

Requests:

☐ **Custom Thermoplastic Splint:** ______________________

☐ **AROM/PROM:** ______________________

☐ **Scar Management:** ______________________

☐ **Other:** ______________________

WSIB ☐ **Yes** ☐ **No**

Signature of Referring Specialist ______________________ Date ______________

Referring Specialist Name Print ______________________ Specialist Billing Number ______________

Specialist Office Phone ______________________ Specialist Office Fax ______________________

For Office Use

Date Referral Received: ______________

Triage By: ______________ Triage Date: ______________

☐ Urgent
☐ Acute List
Physician ______________

Booking Instructions:

____

____

201 Georgian Drive | Barrie ON | L4M 6M2 | 705.728.9802
www.rvh.on.ca

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