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:

________________________________________________________________________