PETERBOROUGH REGIONAL HEALTH CENTRE

Hand Therapy Clinic

Outpatient Rehabilitation Referral Form

1 Hospital Drive Peterborough, ON K9J 7C6
t: 705-740-8351 | f: 705-876-5840

PATIENT LABEL

Please ensure that the referral is fully completed and supporting documents attached before faxing to the department.

Date of referral (DD/MM/YYYY): _____

Patient Name:	Date of Birth (DD/MM/YYYY):	Health Card #:
Address:	TELEPHONE Home: _____ Work: _____ Cell: _____	
Diagnosis:	Date of Onset	
Surgical Procedure:	Date of Surgery	

Reason for referral: ☐ Hand Therapy ☐ Hand Splint

☐ WSIB: Claim Number: _____ Date of Accident: _____

Employer: _____ Address: _____

Employer Phone: _____ Employer Fax: _____

Restrictions/ Protocols /Splinting Information:

Health History/Precautions:

☐ Arthritis	☐ Diabetes	☐ Dyslipidemia	☐ Other:
☐ Allergies	☐ COPD/Asthma	☐ Epilepsy	_____
☐ Cancer: _____	☐ HTN	☐ Liver Disease	_____

Practitioner's Name (please print):	Practitioner's Telephone:
I verify that the above-named patient is appropriate for Hand Therapy **Signature of Referring Practitioner:**	**Date (DD/MM/YYYY):**

FOR OFFICE USE:

K# _____ Account #_____ Initials _____

☐ P1 ☐ P2 Ax Time ☐ 60 ☐ 90 ☐ Other: _____