HOME CARE PROGRAM
REFERRAL FOR OCCUPATIONAL THERAPY AND/OR PHYSIOTHERAPY

Manitoba Health

OFFICIAL USE ONLY	
PHIN #	
Coordinating Agency	Area
Case Coordinator	
MHSC #	

For address, see bottom of form:

Name ☐ Mr. ☐ Mrs. ☐ Miss		Date of Birth	Phone Number
Address			Postal Code
Contact Person	Address and/or Phone Number		
Diagnosis 1)	2)		
Other Health Conditions Important to Therapy			
Clinical History			
SERVICES REQUESTED Splints _____ Exercises _____ Wheelchair _____ Other _____			
ACTIVITIES OF DAILY LIVING Self Care _____ Home Management _____ Walking Education _____			
COMMENTS: Special Precautions (attach sheet with additional comments) Date			
Attending Physician (if Other Than Referring Doctor) Name (Please Print)		Referring Doctor Doctor's Signature	
Address		Address	
	Postal Code		Postal Code / Phone Number
Name of Hospital / Agency Channelling Referral, If Any			

ADDRESS REFERRALS TO THE HOME CARE OFFICE CLOSEST TO PATIENT'S HOME