

## REFERRAL FORM

(Fax to: (902) 201-8327)

Can be completed by client/family, health professional, or funding source

<b>Full Name:</b> _____ <b>Health #:</b> _____	<b>Age:</b> _____ <b>DOB:</b> ____/____/____ Year Month Day	<b>Category:</b> <input type="checkbox"/> Adult <input type="checkbox"/> Adolescent <input type="checkbox"/> Child
<b>Mailing Address:</b>  		
<b>Preferred Phone #:</b> _____ Permission to leave message: <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Email address:</b>  	
<b>Type of Service Requested (Need to select at least one)</b>		
<u><b>Occupational Therapy</b></u> <input type="checkbox"/> OT for Kids <input type="checkbox"/> OT for Adults <input type="checkbox"/> OT for Veterans/First Responders	<u><b>Counselling Services</b></u> <input type="checkbox"/> Counselling for Kids <input type="checkbox"/> Counselling for Adults <input type="checkbox"/> Counselling for Veterans/First Responders	
<b>Reason for Referral:</b>  		
<b>Please Note:</b> We are a private practice clinic. Please view the Rates & Policies on our website for details. <a href="http://www.stratfordot.com/rates-policies">www.stratfordot.com/rates-policies</a>		
<b>Please indicate planned method of payment for services:</b>  		
<b>Date:</b>	<b>Signature:</b>	
<b>Assigned To:</b>		