PHYSIOCARE AT HOME

Halifax Office (902) 404-4200
Toll Free 1-855-855-0550

Please Fax Referral to: (902) 404-4201

www.physiocareathome.com

HOME PHYSIOTHERAPY REFERRAL FORM

Patient Name: _____
Patient Phone: _____
DOB (dd/mm/yyyy): / /

Diagnosis/Relevant Medical History:
_____
_____
_____
_____
_____
_____

Reason for Referral: _____
_____
_____

Physiotherapy Requested

- ☐ Evaluate & Treat
- ☐ Falls Assessment & Prevention
- ☐ Home Safety Evaluation
- ☐ Pain Management
- ☐ Home Exercise Program
- ☐ Assistive Device/ Mobility Equipment prescription
- ☐ Gait / Balance Training
- ☐ Physiotherapy for Musculoskeletal or Neurological Deficits
- ☐ Pre and Post-Operative Recovery Program and Reconditioning
- ☐ Self-Care & Transfer Training
- ☐ Evaluate & Recommend Home Assistive Devices
- ☐ Symptom Management for Chronic Pain, Fatigue & Sleep issues
- ☐ Cardiorespiratory PT for Heart & Lung
- ☐ Other: _____

Precautions

- ☐ Weight Bearing: _____ (Non/Partial/Full)
- ☐ Range of Motion: _____ (Passive/Active Assisted/Active)
- ☐ Present Mobility Status: _____
- ☐ Neurological Deficits: _____
- ☐ Alzheimer's and/or Dementia
- ☐ Cardiovascular: _____
- ☐ Other: _____

Goals

- ☐ Improve Balance
- ☐ Improve ROM
- ☐ Improve Strength
- ☐ Improve Mobility
- ☐ Improve Function
- ☐ Manage Pain/Fatigue
- ☐ Other: _____

Other

- ☐ Caregiver training with back care and lifting practice & principles
- ☐ **Relevant Imaging Findings Attached**
- ☐ Additional Comments: _____
  _____
  _____
  _____

Physician:
Phone:
Fax:
Signature: _____

Helping Seniors Live Healthy & Fulfilling Lives