



Vancouver Island (250) 800-1687
Lower Mainland (604) 492-0788

Please Fax Referral to: (604) 492-0789

www.physiocareathome.com

HOME PHYSIOTHERAPY REFERRAL FORM

Patient Name: _____

Patient Phone: _____

DOB (dd/mm/yyyy): / /

Diagnosis/Relevant Medical History:

Reason for Referral: _____

Physical Therapy 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