



CAIRNS OCCUPATIONAL THERAPY

REFERRAL FORM

Client's Name:	DOB:
Address:	Funding source:
Ph:	Claim Number:
Treating Doctor/s:	Other Services Attending:
Ph: Fax:	

Background Information/Medical conditions:

Services Requested:
Desired Service Commencement Date:

Further Comments	Referred By:	Date:
If this is a DVA client please send D904 form.	Email:	
	Ph:	Fax:

Helping you with...

- ♦ Hand and Upper Limb Therapy ♦ Wound and Scar Management ♦ Rehabilitation following surgery
- ♦ Soft Tissue Injury Management from a whole person perspective ♦ Personalised Wellness Programs
- ♦ Lymphoedema Management ♦ Burns management ♦ Consultancy to Residential Aged Care Facilities
- ♦ Home Assessment ♦ Adaptive Equipment Prescription ♦ Medicolegal Assessment
- ♦ Worksite Assessments ♦ Pre Employment Screenings ♦ Functional Capacity Evaluations
- ♦ Return to Work Programs ♦ Ergonomic Advice ♦ Injury Prevention Group Training

