CAIRNS OCCUPATIONAL THERAPY

REFERRAL FORM

E mail to referrals@cairnsot.com

Client name: (or label) **DOB:**	**Funding source:** **Claim no:** If this is a DVA client please send D904 form / referral on your letterhead.
Client address:	**Client phone:**

Diagnosis and Background Information:

Services Requested / Instructions:

Referred by:	**Date:**
Email: **Phone:**	

Cairns Occupational Therapy is your centre for

- Hand, wrist and arm therapy
- Scar, swelling and lymphoedema management
- Pain management therapy
- Neurological rehab eg stroke, ABI, progressive neuro conditions
- Work rehabilitation services

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