EXTENDED THERAPY SERVICES
Outreach Therapy
4325 Neill Street, Port Alberni, B.C. V9Y 1E5
Phone: 250-723-1117 / Fax: 250-723-7349

OT REFERRAL

Referral Date: _____
DA / MO / YR

Child's Name: _____ Sex: _____ DOB: _____
LAST, First **DA / MO / YR**

Parent(**s**) / Foster Parent(**s**): _____

Mailing Address: _____

Postal Code: _____ Telephone: (Home) _____ (Work) _____

Email: _____

Legal Guardian(**s**): _____ ☐ USMA ☐ MCFD

Family Doctor: _____ Paediatrician: _____

Occupational Therapy:

☐ **Occupational Therapy under the Autism program for children who are over 6 years of age**
These services are offered by a RASP certified therapist.

☐ **Occupational therapy for school-aged children who qualify for the At-Home Program**

☐ **Privately funded occupational therapy assessments and treatment**

Reason for Requesting Service:

_____

_____

_____

What has been done so far to address these concerns? _____

_____

_____

Referred by: _____ Position: _____

Address: _____

Telephone: _____ Information Taken By: _____