Oakville Trafalgar Memorial Hospital
905-338-4613
FAX: 905-815-5109

Milton District Hospital
905-876-7022
FAX: 905-876-7005

Name: ______________________________

D.O.B ______________________________

Health Card: ___________________________

Telephone: (Home) _____________________

(Cell): _________________________________

Outpatient Hand Therapy Program Referral

Occupational Therapy or Physiotherapy

CLASSIFICATION:
❒ Outpatient ❒ Inpatient (Entered in Order Entry) ❒ Urgent ❒ W.S.I.B. ❒ MVA

REFERRING DIAGNOSIS: **❒ LEFT** **❒ RIGHT**

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HAND THERAPY: ❒ AROM 3x/Day ❒ Edema Management ❒ Mallet Protocol ❒ Strengthening ❒ Sensory Retraining
❒ Buddies ❒ PROM ❒ Wound Care ❒ Scar Care ❒ Tendon Rehab ____________________________

CUSTOM THERMOPLASTIC ORTHOSIS:
❒ Forearm-based ❒ Hand-based ❒ Digit-based ❒ IP Free ❒ To the Tip(s)

❒ Thumb Spica ❒ Stack ❒ Dorsal Block ❒ Ulnar Gutter ❒ Radial Gutter ❒ Volar Slab ❒ Relative Motion ❒ Serial Casting

❒ Other: ____

TREATMENT GOALS: ____

Date of Onset of Injury / Procedure:

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Referral Criteria:
❒ Recent Surgery/Fracture
❒ Acute Conditions: 6 weeks or less

♦ Have X-Rays Been Taken? ❒ No ❒ Yes – If not at Halton Healthcare, please have patient provide CD or electronic access to x-rays

Physician's Signature: ______________________ Date: _______________

Physician's Name (Print): ____________________________________

Fracture Bracing Delegation Accepted by: ____________________________

NEXT APPOINTMENT WITH PHYSICIAN:

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Hand Therapy Team Use Only Date Referral Received: ______________________________

TREATMENT PROVIDED:

- ❒ Patient fitted with custom thermoplastic orthosis ______________________________ ❒ Buddies ______
- ❒ Wearing schedule reviewed ____
- ❒ Precautions ____
- ❒ Edema Management education provided including: ❒ Elevation ❒ Contrast Baths ❒ Retrograde Massage ❒ Coflex
- ❒ ROM reviewed and handout provided____
- ❒ Contact information provided
- ❒ Scar Management including: ❒ Silicone ❒ Scar Massage ❒ Sun Protection ❒ Sensory Retraining
- ❒ Comments: ____

  ____
- ❒ Patient/SDM verbally consents to the assessment and treatment plan, the nature of which has been explained to him/her/them and financial arrangements when applicable. He/she/they understands the risks, benefits of treatment and consequences of declining treatment.

Therapist Name: ____________________________ Therapist Signature: ____________________________

Appointment Booking: ____

Attempts to Contact Patient: Date _____________________ Time ______________ Clerk ______________

Date _____________________ Time ______________ Clerk ______________

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