BLOOMING ABILITIES
Pediatric Occupational Therapy

Date: _____

OCCUPATIONAL THERAPY REFERRAL FORM

CLIENT INFORMATION:

Child's Name: _____ Date of Birth (year/month/day): _____

Diagnosis (if any): _____ Age: _____

Parent(s)/Guardian(s): _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (home): _____ Email: _____

Phone (work): _____ Phone (cell): _____

GENERAL INFORMATION:

Physician/Pediatrician: _____ Phone: _____

School/Preschool/Daycare: _____ Grade (if applicable): _____

Contact Person & Title: _____ Phone: _____

_____

Other Professionals Involved (e.g. PT, SLP): _____

Phone Number(s): _____

Referred by: _____

Reason for referral: _____

_____

Please indicate your goals for your child's attendance in group: _____

_____

_____

If available, please attach:
□ Printing Samples
□ Clinical Reports (e.g. SLP, PT, CDC, OT)

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"Helping children blossom to their full potential"

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