HAWKE'S BAY
District Health Board
Whakawāteatia

Fill in only if patient label is unavailable

Name: ..... DoB: .....

NHI: ..... Phone: .....

Address: .....

.....

REFERRAL FOR OUTPATIENT OCCUPATIONAL THERAPY

Referral for Outpatient Occupational Therapy Service

Date: ..... **ACC No:** .....

Patient phone number: ..... **Other contact number:**.....

Please tick service required:

- ☐ **Neurological Rehabilitation –** upper limb treatment, cognitive and/or perceptual rehab including memory, problem solving and concentration, and return to work (non ACC)
- ☐ **Burn and Scar Management**
- ☐ **Driver Assessment**
- ☐ **Education and Advice** – fatigue, stress management and energy conservation

Diagnosis, CT Result/ Relevant Medical History:.....

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Date of Injury/ Medical Event .....

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Current Level of Ability: (cognition, physical abilities, arm function etc) .....

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Reason for Referral: (e.g. to improve arm function in order to dress independently) .....

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Medical/Visual Clearance i.e. for driver assessment:

Discharge Summary: ☐ **Stroke Screen:** ☐ **Standardised Assessment:** ☐

Name: ..... Designation: .....

Signature: ..... Date: .....

Please send referral to:
Fax: 06 878 1380 **Enquires to: 06 878 1304**