StevensOT

Expert OT, where life actually happens

Physician Referral Form

stevensot.com | Fillable PDF — type directly into the fields

REFERRING PHYSICIAN / CLINICIAN

Phvsician / Clinician Name

Clinic / Practice Name

Phone

Email

Date of Referral

PATIENT INFORMATION

Patient Full Name

Date of Birth

Phone

Preferred Contact Method / Best Time

Email (if applicable)

☐ By checking this box, the referring provider confirms the patient has consented to their contact information being shared with StevensOT for the purpose of scheduling an occupational therapy assessment.

REASON FOR REFERRAL (check all that apply)

☐ Physical health (fatigue, chronic pain, deconditioning)

☐ AADL equipment assessment

☐ Cognitive health (MCI, dementia, Alzheimer's)

☐ Cognitive rehabilitation (post-concussion, TBI, brain injury)

☐ Mental health (anxiety, depression, burnout, workplace stress)

☐ Sleep (CBT-I, insomnia)

☐ Return-to-work support

☐ Other (specify below)

Other / additional detail

URGENCY

☐ Routine

☐ Time-sensitive (e.g., WCB / return-to-work deadline)

If time-sensitive. note the deadline / context

Once complete, save this file and email it to vik.stevens@hotmail.com. Questions: 1-438-825-8596.

Patient information is collected and stored in accordance with Alberta's Personal Information Protection Act (PIPA). See stevensot.com/privacy.

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CLINICAL BACKGROUND

Relevant diagnoses

Medications relevant to sleep / cognition / function

Prior or current related treatment

Relevant precautions / safety considerations

ADDITIONAL NOTES FOR STEVENSOT

PHYSICIAN SIGNATURE

Signature (type full name)

Date

Thank you for trusting StevensOT with your patient's care.

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