



Capital Health

Mobile Outreach Street Health Occupational Therapy Referral

Tel: 902-802-7785 Fax: 902-429-8319 Email: rmarval@neche.com www.moshhalifax.ca (download form)

Referral Pre-requisites: Consent for referral: Y/N Housing Vulnerability: Y/N

Name: Age/DOB: Sex/Gender: Known to North End Clinic: Y/N*
*If No or Unsure – HCN: & Family Physician:

Health Status/History:

Housing Status/History:

Requesting: Individual Group Consultation (to staff) Event/Program/Community Development

Reason for Referral: (Check all that apply, if can be expected modifiable by OT involvement)

- | | | |
|--|---|---|
| <input type="checkbox"/> Skills/Deficit Evaluation | <input type="checkbox"/> Health/ Meds/ Symptom Mgt | <input type="checkbox"/> Behavioural |
| <input type="checkbox"/> Property/Home Mgt | <input type="checkbox"/> School/Learning / Work | <input type="checkbox"/> Developmental Milestones |
| <input type="checkbox"/> Shelter/Tenancy Demands | <input type="checkbox"/> Meal Prep/Food Security | <input type="checkbox"/> Emotional/Mental Health |
| <input type="checkbox"/> Mobility/Falls | <input type="checkbox"/> Community Engage/ Volunteer | <input type="checkbox"/> Cognitive/Perceptual |
| <input type="checkbox"/> Leisure/Play | <input type="checkbox"/> Parenting/ Caregiving | <input type="checkbox"/> Social/ Interpersonal |
| <input type="checkbox"/> Budget/Financial Mgt | <input type="checkbox"/> Environmental Assessment | <input type="checkbox"/> Physical |
| <input type="checkbox"/> Shop/Errands/Transport | <input type="checkbox"/> Discharge/Transition Planning | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Client /Staff Education: Condition's functional impact, Strategies, Prevention, etc. | |

What do you Hope to Achieve with OT Involvement?

List Other Supports in Place & Contact Info: (housing, health/social workers, guardian, trustee etc.)

Other Considerations: (literacy, precautions, etc.)

Method to Initiate OT Involvement:

- Contact client directly (Info/Method):
- Contact referral source/other (Info/Method):

Referral Source: Tel: Fax: Date:
Involvement with client:

Triage: Immediate Priority General Relevant Deadlines (d/c, eviction):

MOSH USE ONLY

Date referral received:
Reason for discharge (see codes):

Wait time (days) to first attempted contact:
Date discharged