**Physiotherapy Referral Form**

**Richmond Paediatric Team**

Richmond Public Health

8100 Granville Avenue

Richmond, BC V6Y 3T6

Phone: (604) 233-3150 Fax: 604-233-3198

Email: [rhspeds@vch.ca](mailto:rhspeds@vch.ca)

***Criteria for Physiotherapy service:***

* Students who have a physical disability or a diagnosis with a significant impairment of mobility e.g. they require lifting
* Students who have equipment or major physical concern that affect their mobility e.g. walkers, wheelchairs
* Students who have health or safety concerns relating to their mobility or safety concerns for caregivers e.g. frequent falls

**\* *Please complete all areas on this form***

*1.* ***General Information:***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referral Date** | Child’s Last Name | | Child’s First Name | Child’s Preferred Name | |
| Personal Health Number | Date of Birth (dd/mmm/yyyy) | | Primary Language(s) | Interpreter needed? *(no cost)*  Yes  No | |
| Gender | Preferred Pronouns | | Preferred Phone Number | Alternate Phone Number | |
| Address (*including city and postal code*) | | | | | |
| □ Parent / □ Legal Guardian /□ Foster Parent (first and last name) | | | □ Parent / □ Legal Guardian / □ Foster Parent (first and last name) | | |
| Additional Phone Number(s) | | Preferred Pronouns | Additional Phone Number(s) | | Preferred Pronouns |
| Email | | Relationship to Child | Email | | Relationship to Child |

|  |  |
| --- | --- |
| School: | Grade: |
| Teacher | Resource Teacher: |
| Social Worker (if known): | Speech/Language Pathologist: |

*2.* ***Specialists or Agencies Involved:***

Family Doctor:       Phone:

Referral to and/or involvement with other agencies or professionals:

BC Children’s Hospital  Private Physiotherapist/Private Occupational Therapy

Sunny Hill Health Centre  OT Fine Motor Consultation/Waitlist/Referral

Centre for Ability  Other

Clinics/Names:

Pertinent Medical History: (including diagnosis, seizures, medications)

Diagnosis

Medications:

Other

**Reason for Referral:**

Primary concern from the school:

Primary concern from family:

Physical concerns: *Please check off and explain if the child is having difficulties in any of the following areas:*

Safety  Mobility (walkers, wheelchair, walking)

Transfers  Building accessibility (including bathroom)

Equipment - commodes, orthoses/splints

Describe:

School Performance concerns: *Please check off and explain if the child is having difficulties in any of the following areas:*

Balance  Running  Behaviour

Strength  Jumping  Attention

Coordination  Climbing  Hearing/Vision

Fatigue  Learning New skills  Speech/Language

Organizational Skills  Ability to follow directions  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe:

Is the child currently performing at grade level in all areas of the academic curriculum?  Yes  No

If no, what areas are being modified?

How does the concern interfere with school activities?

What have you already tried to help the student with this concern?

Form completed by:       Date:

Telephone:       Email:

Parent/ Legal Guardian has been contacted about this referral and given verbal consent for initial assessment?

Yes  No

**Functional Movement in the School Environment**

It is often assumed that all students who have a disability will require physiotherapy. This is not always the case and it is important to determine the child’s functional mobility and the impact that any difficulties have on the child’s ability to participate in school.

Please complete the following checklist:

1. Requires assistance or lifting to move from one position or activity to another – describe the type of assistance needed:

None – Independent  Lifted by two persons

Independent but needs supervision  Lifted using a mechanical lifting device

Assisted standing transfer – 1 or 2 persons  Other:

2. Uses a wheelchair or other mobility aid:

Uses crutches  Uses power wheelchair

Uses walker – describe type  Uses an adapted tricycle

Uses manual wheelchair  Other:

3. Uses splint or other orthotic device at school

Ankle Foot Orthoses (ankle splint)  Shoe inserts

Thoracic Lumbar Sacral Orthoses (back brace)  Other:

Knee Ankle Foot Orthoses (leg brace)  Do they come on/off at school

4. Other specialized equipment/furniture

Desk  Other:

Standing frame  Other:

5. Physical/Mobility concerns (please describe in detail)

Has difficulty changing positions as required at school (e.g. down to and up from the floor)

Describe:

Has difficulty negotiating stairs – Describe:

Falls often – Describe:

Other:

Please provide additional information especially if there are:

* Heath and safety concerns
* Issues regarding the child’s accessibility to school and the ability to participate in the school program.