



RENAL OCCUPATIONAL THERAPY

Health Sciences Centre
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Renal Occupational Therapy Referral Tool

Demographics and Dialysis Schedule

New Start

Client Name:	Date of Birth:	PHIN:				
		MRN:				
Days of dialysis	MWF	TTS				
Time of dialysis	AM	AFT	PM			
Unit for dialysis	CDUA	CDUB	JM5	SCDU	RHC	LRHC

Please select reason(s) for referral:

- Mobility Assessment
 - Gait aid assessment
 - Transfer assessment
 - Details of fall history (reason/frequency) _____

- Seating/Positioning Assessment
 - current w/c user
 - Wheelchair Prescription
 - power w/c
 - manual w/c
 - Seating System Components
 - backrest
 - cushion

- Functional Assessment (equipment, activities of daily living)

- Skin/Wound/Pressure Management
 - infected
 - Date of onset (approximate) _____
 - Wound stage _____
 - Wound location _____

- Cognitive Concern:(description) _____

- Upper Extremity Concern: (description) _____

Additional Information

Please fax referral to 204-940-2411.

Referral Source _____ Phone _____ Date _____
(PRINT NAME)