

**WESTERN ISLES NHS BOARD: COMMUNITY HEALTH SERVICE
OCCUPATIONAL THERAPY REFERRAL**

STYLE: MR MRS MISS MS REV DR
 NAME.....
 ADDRESS.....

 D.O.B.....
 TEL NO

CHI NUMBER.....
 HOSPITAL.....
 WARD.....
 DATE OF ADMISSION.....
 DATE OF DISCHARGE

LIVES ALONE YES/NO
 CONSENT GIVEN YES/NO

G.P.
 CONSULTANT
 CONTACT PERSON

REFERRED BY

NAME:
 RELATIONSHIP:
 ADDRESS:
 TEL: NO.

NAME:
 RELATIONSHIP:
 ADDRESS:
 TEL: NO.

DIAGNOSIS	PAST/RELEVANT MEDICAL HISTORY
MOBILITY	HOME CIRCUMSTANCES/EXISTING SUPPORT

MAIN PROBLEMS AS REPORTED

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REFERRAL COMPLETED BY DATE

For office use only	Speciality	Previously known to service			Referral received	Priority		allocated to	
		ALLOC. TO	N.F.A.	PRIORITY		O.T.	O.T.A.	INITIALS	DATE
					DATE				