Adaptive Seating Service Request

Stan Cassidy Centre For Rehabilitation

Centre de réadaptation STAN CASSIDY Centre for Rehabilitation
Towards Independence / Vers l'autonomie

800 Priestman Street
Fredericton, N.B.
E3B 0C7
Tel: (506) 452-5411
Fax: (506) 452-5374

Service Preference (check one box only)**:**
☐ Ambulatory/Outpatient
☐ Outreach

Language Preferred:
☐ English ☐ No preference
☐ French ☐ Other: _____

☐ **Family/patient is aware of referral**

Name of Patient: _____
(last name, first name)

Address (home): _____

Current client location (home, hospital, other): _____

Contact person: _____

Telephone: (home) _____ (work) _____

Medicare: _____ Exp. Date: _____

Date of Birth: _____ _____ _____
dd mm yy

School: _____

REQUEST FOR SERVICE/CONSULTATION TO Adaptive Seating Services:

☐ **Seating and Positioning**
☐ **Manual mobility**
☐ **Power mobility**

DIAGNOSIS: _____

SPECIFIC REASON FOR TERTIARY REFERRAL:
1. _____
2. _____

GOAL(S):
1. _____
2. _____

CURRENT THERAPY SERVICES (includes Hospital Services, Extra Mural Programs, Private Practices, School, etc.)

Therapist/Physician	Discipline	Report Enclosed	Organization	Phone #
		☐		
		☐		
		☐		
		☐		
		☐		
		☐		

Person requesting Service: _____ (Print) _____ (Telephone #) ____ (dd) ____ (mm) ____ (yy)

Referring Physician: _____ (Signature) _____ (Print or stamp name) ____ (dd) ____ (mm) ____ (yy)

***** Incomplete Referrals Will Be Returned For Completion Prior To Acceptance *****