Bennett Occupational Therapy

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13 - 567 Coverdale Road Riverview NB E1B 3K7

Date of Referral: _____
DD/MM/YYYY

CLIENT INFORMATION	
Name:	**Date of Birth:**
Age:	**Gender:**
Address:	
Home Phone #:	**Cell Phone #:**
Email:	
Medicare #:	**Expiry Date:**
NB Social Development #:	**Expiry Date:**
Referred By: (*Please indicate the relationship to the client)*	
Reason for Referral:	
Type of Service/ Assessment Required (select all that apply): Mobility Assessment (*Wheelchair/ mobility aids*) Wellness (*mental health, cognitive and TPI*) Longterm Care (*care planning and dementia care)* Pediatric Occupational Therapy Home Safety Home Accessibility Medical Legal	
Do you have a preferred Medical Supplier for equipment?	**Yes** **No**
If Yes, please indicate which supplier:	
Person to contact for scheduling <u>all</u> appointments: (*Please indicate the relationship to the client)*	
Name:	**Phone #:** **Cell:**

Email Address:	
Relationship to Client/Role:	
Person(s) who must attend and/ be informed of appointments and/ or intervention:	
Name:	**Phone #:**
Email Address:	
Relationship to Client/Role:	
Other contacts: (Caregiver, School staff, Power of Attorney)	
Phone #:	
MEDICAL REFERRAL INFORMATION:	
Family Physician:	
Phone #:	**Fax #:**
Other Specialists:	
Diagnosis and Medical Information:	
FUNDING INFORMATION:	
Funding for Equipment: ☐ **Insurance** ☐ **Private pay** ☐ **WorkSafe**	
NB Social Development (Incl. Co-pay)	
Name on Insurance policy:	
ID Policy Claim #:	**Expiry Date:**
BILLING INFORMATION FOR OCCUPATIONAL THERAPY SERVICES:	
Contact Name:	
Address:	
Phone #:	**Email:**