WEB: www.maplehandtherapy.ca
EMAIL: info@maplehandtherapy.ca
TEL: 647-576-7007
FAX: 647-480-5065

Maple Hand Therapy
For your custom splinting needs

1051 Markham Road, Scarborough, ON, M1H 2Y5
(Located inside Maple Health Clinic)

REFERRAL FORM

Patient/ Client Information		
First and Last Name:	Date of Birth (DD/MM/YYYY)	
Address (Street Number/Name, City, Province, Postal Code):		
Health Card Number:	Phone Number (Home/Cell):	Email Address:

Reason for Referral	
Diagnosis: Date of Onset of Injury/Procedure (DD/MM/YYYY):	Affected Side? Left ☐ Right ☐

Treatment Goals:		Special Instructions:
☐ Edema Control	☐ Active ROM	
☐ Pain Control	☐ Passive ROM	
☐ Scar Management	☐ Strengthening Exercises	
☐ Desensitization	☐ Custom Brace/Splint	
☐ Other:		

Please attach any relevant diagnostic imaging reports and/or consultation notes

Referred By	
Healthcare Provider Name, Designation and Registration Number:	
Healthcare Provider Signature:	Date (DD/MM/YYYY):

Once completed, please fax/email this referral and ensure a copy is provided to the patient