Vancouver Paediatric Team
Pacific Spirit Community Health Centre
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HOSPITAL REFERRAL TO VANCOUVER PAEDIATRIC TEAM

Therapist to Therapist Handover Tool

(To be filled out by PT and/or OT prior to discharge)

Date of referral: Anticipated discharge date:

Last name: Legal First name:

DOB: PHN:

Address:

Parents / Guardians names:

Phones: Home Cell(s)

Email(s):

Language(s) at home: Is an interpreter needed? Y☐ N☐

School:

Rehab Goals	Comments
☐ Pre Discharge Home Visit (for home equipment recommendations)	
☐ Community / Home / School Accessibility	
☐ School integration (incl. training staff re mobility and safety, feeding)	
☐ ROM/ Strength/Endurance Training	
☐ Progress mobility	
☐ Positioning (ADL or classroom supports)	
☐ Swallowing	
☐ Assistive Technology	
☐ Other:	

DIAGNOSIS: Hospital Admission Date:

Surgery /Procedure
(include date):

Precautions / Contraindications
/Safety Concerns:

Past Medical History:

Weight Bearing Status:

Clinics involved after discharge (please tick and provide primary therapist):

- ☐ Positioning/Mobility – Therapist:
- ☐ Assistive Technology – Therapist:
- ☐ Ortho clinic – Next appointment:
- ☐ Other - (*Specify):*
- ☐ Private therapist**:**

Activities of Daily Living (*please tick the current level of assistance required*)

	Independent	Supervision	Assist	Dependent
Bathing	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Feeding	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Swallowing/oral motor considerations? Y☐ N☐ Please explain:				

Mobility (*please tick the current level of assistance required*)

	Independent	Supervision	Assist	Dependent
Bed mobility	☐	☐	☐	☐
Transfers	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐
Stairs	☐	☐	☐	☐
Wheelchair N/A ☐	☐	☐	☐	☐
Gait aid/endurance: walker ☐, crutches ☐, cane ☐, other ☐				

- Safety insight:
- PE recommendations:
- Behaviour consideration:

Home equipment in place (or pending) upon discharge:

Please discuss with VPT therapist if you are prescribing equipment in the home (e.g. mechanical lifts, commodes, hospital beds etc.)

Home Equipment	Funding source	In place? (Y/N)
		Y☐ N☐
		Y☐ N☐
		Y☐ N☐
		Y☐ N☐

Splints / Orthoses	Wear recommendations	Provided by / follow up by:

Referrer: (*Please tick one)* PT☐ OT☐ Phone: