Gleneagles™ HONG KONG 港怡醫院

Allied Health Referral Form (OT / P&O / Speech)

Patient Label

Patient Name:_____ Age / Sex:_____

Refer for: ☐ Occupational Therapy ☐ Orthotic & Prosthetic ☐ Speech Therapy

Diagnosis: _____

Recommended Occupational Therapy:

- ☐ Cognitive perceptual assessment and training
- ☐ Hand function assessment and training
- ☐ ADL assessment and training
- ☐ Assistive device assessment and training
- ☐ Pressure garment
- ☐ Others : _____

Recommended Prosthetic & Orthotic Service:

- ☐ Prosthetic Service : _____
- ☐ Orthotic Service: _____
- ☐ TLSO : _____
- ☐ Bracing : _____
- ☐ Others: _____

Recommended Speech Therapy:

- ☐ Speech disturbance
- ☐ Other Symbolic Dysfunction
- ☐ Apraxia of Speech
- ☐ Dysphagia / difficulty swallowing
- ☐ Voice disturbance
- ☐ Others:_____

Date:_____ Dr's Signature :_____

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