OCCUPATIONAL THERAPY DEPARTMENT
REFERRAL FORM
SEATING CLINIC

TO : Seating Clinic	**REFERRAL FROM** :
DEPARTMENT: Occupational Therapy	**DATE OF REFERRAL:**

CLIENT'S PARTICULARS:

Name:

Sex / D.O.B:

Programme: ☐ School ☐ GROW ☐ DAC ☐ EIPIC ☐ HMP ☐ OP

Class:

DIAGNOSIS:

CLIENT IS CURRENTLY RECEIVING SERVICES FROM:

- Occupational Therapist Name / Organization: _____
- Physiotherapist Name / Organization: _____
- Speech Therapist Name / Organization: _____

REASONS FOR REFERRAL:

Client is having difficulty with (please tick all that apply):

☐ Sitting in a normal chair ☐ Pressure relief

☐ Performing school/ Job related tasks ☐ Feeding

☐ Mobility ☐ Social interaction

☐ Others(specify): _____

(Please briefly describe how client's current seating system is affecting his/her ability to function**):**

_____

_____

_____

SIGNATURE OF REFERRING STAFF: _____

CONTACT NUMBER: _____(O/ H) _____(HP)

Cerebral Palsy Alliance Singapore
Cerebral Palsy Centre
65 Pasir Ris Drive 1 Singapore 519529
Tel: 6585 5600 Fax: 6585 5603 www.cpas.org.sg