



PLEASE PRINT

Therapeutic Recreation Referral Form
(Please complete this application in full to avoid delay in process)

PARTICIPANT INFORMATION

SECTION 1

Name: _____ Date of Birth: dd ____ mm ____ yy ____
Address: _____ City/Town: _____
Postal Code: _____ Email: _____
Home Phone: _____ Cell Phone: _____
Emergency Contact: _____ Relation: _____ Phone: _____

REASON FOR REFERRAL

SECTION 2

Please select all that may apply:

- Improvement in physical health
- Community reintegration
- Increase social opportunities
- Financial support
- Unaware of recreation and leisure opportunities available
- Reduction of symptoms for pain, stiffness and improved bone/muscle strength
- Reduction in health risk factors (falls, body weight, mobility, blood pressure)
- Improved cognitive functioning (memory, attention, alertness, problem-solving)
- Reduction or anxiety, stress, passivity, depression etc.

REFERRAL INFORMATION (if completed by health profession please complete the following)

SECTION 3

- Self-referral
 - Referral by organization
- Referral made by: _____ Job Title: _____ Signature: _____
Organization: _____ Phone: _____ E-mail: _____

CLIENT CONSENT

SECTION 4

I authorize the assigned above to release the information disclosed in this document to the City of St. John's Inclusive Services.

Consent Given: Yes No Client Signature: _____ Date: _____

THERAPEUTIC RECREATION ASSESSMENT – OFFICE USE ONLY

SECTION 5

Date Received: _____ By: _____
TR Assessment complete by: _____ Date Completed: _____
Recommendations: _____
Assessment Attached: Yes No