WINCHESTER HOUSE
HEALTHCARE AND REHABILITATION

FOURTH FLOOR MEMORY CARE UNIT THERAPY REFERRAL FORM

Resident's name: _____ Room number: _____ Date of referral: _____

Referred for:

- ☐ Swallowing Evaluation
- ☐ Use of assistive devices for eating
- ☐ Reduce need for feeding assistance
- ☐ Instruction for care team on how to cue the resident during meals
- ☐ Fall prevention evaluation
- ☐ Evaluation after a fall
- ☐ Safe transfers
- ☐ Balance/Gait
- ☐ Use of assistive devices for walking
- ☐ Decline in ability to participate in ADLs, in mobility, or in ambulation
- ☐ Wheelchair positioning/fit
- ☐ Trunk control
- ☐ Defensive (Combative) during care
- ☐ Behavior management
- ☐ Signs of depression
- ☐ Customized activity kit
- ☐ Instruction for care team on how to cue the resident during ADL routine care
- ☐ Contractures
- ☐ Wound care
- ☐ Breathing
- ☐ Cognitive assessment
- ☐ Speech
- ☐ Pain treatment

Comments: _____

Referred by: _____ Evaluated by: _____date: _____