Constraint Induced Movement Therapy
Occupational therapy clinic referral form

A clinic for people who have difficulty using their hand and arm following stroke.

It is a two week intensive program using an innovative approach called Constraint Induced Movement Therapy or CIMT.

Interested participants must be able to commit to attending the program for four hours each day (Monday to Friday) for a period of two weeks, with 2 additional visits for assessment/reassessment:

Eligibility Checklist: Please tick the box. Does the client:	**Yes**	**No**
1. Have a stroke diagnosis or other neurological condition that has impacted on use of their hand and arm	☐	☐
2. Have some ability to move their wrist and straighten their fingers, even if these movements are very weak	☐	☐
3. Have capacity to attend the clinic daily for two weeks (Monday to Friday) and participate in 4 hours of varied activities each day	☐	☐
4. Have cognitive and communication skills sufficient to participate in a small group intensive program.	☐	☐
5. NOT HAVE severely increased muscle tone (severe hypertonicity) of their wrist and finger flexor muscles	☐	☐

CLIENT INFORMATION:

Client Name: _____ Date of Birth: _____

Address: _____

_____

Telephone/mobile: _____ Email Address: _____

Own transport: ☐ Yes ☐ No

Diagnosis: _____ Date of stroke or event: _____

Precautions/allergies/alerts: _____

REFERRING PRACTITIONER:

Name: _____

Organisation: _____

E-Mail Address _____ Phone No: _____

Reason for referral and what you would hope your client to achieve in this clinic program:

_____

_____

Has this referral been discussed with your client: ☐ Yes ☐ No

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Date Received: _____ Date Contacted: _____

Contacted by _____ Outcome _____

CRICOS Reg: 00004G