**SCHOOL OF OCCUPATIONAL THERAPY**

**SPRING 2025 CAMPUS-BASED ADULT TEACHING CLINIC**

The School of Occupational Therapy Student Teaching Clinic provides **FREE** services to community volunteers. Each session is led by a graduate level occupational therapy student, supervised by a licensed OT.
To be considered for an appointment, please complete pages 1-2 and **have a qualified healthcare provider (MD or ARNP) complete and sign page 3: referral for occupational therapy evaluation and intervention**. Please then return all three pages to the School of Occupational Therapy by fax **or** by mailing to the address on page 3.

| **PARTICIPANT INFORMATION** | | |
|---|---|---|
| Name: | | |
| Current address: | | |
| City: | State: | ZIP Code: |
| Phone (Home / Cell): | Have you attended this clinic before? Y N | |
| Alternate Phone (Home / Cell / Work): | | |
| Date of Birth: | Preferred pronouns: | |
| Email: | | |

| **PARTICIPANT EMERGENCY CONTACT** | | |
|---|---|---|
| Name: | | |
| Address: | | |
| City: | State: | ZIP Code: |
| Phone: | Email: | |
| Relationship: | | |

| **PARTICIPANT COMMUNICATION INFORMATION** |
|---|
| Please check all methods that we can use to contact you about appointments:<br>Phone: _____<br>Can we leave a detailed message at this number? ___Yes___No<br>Email: _____<br>*Please be advised that information shared via email will be limited to appointment details in order to protect your personal health information.* |
| Participant Name: |
| Guardian Name (if applicable): |
| Participant or Guardian Signature: |

| **PARTICIPANT REASON FOR REFERRAL** |
|---|
| Diagnosis/Health Condition(s): |
| Why would you like to participate in our campus-based teaching clinic at the University of Puget Sound? |
| Please list any other occupational therapy services that you are currently receiving, or have received in the past several years, and the location of those services (hospital, clinic, etc.): |
| Please check any of the following that you would like to work on during the teaching clinic sessions:<br><br>__ self-care (eating, dressing, bathing, etc.)<br>__ cooking<br>__ home maintenance/household chores<br>__ leisure activities and/or socializing<br>__ community mobility (driving, public transportation)<br>__ return to work<br>__ other: _____ |

*Participants must commit to both **Tuesday AND Thursday** sessions throughout the semester.*

Please indicate your available times by marking 1 & 2 for your top two preferences below:

___ 8:00-8:45 am

___ 9:00 - 9:45 am

___ 10:00 - 10:45 am

___ 2:30 - 3:15 pm

___ 3:30 - 4:15 pm

- ***Prior to acceptance and scheduling, <u>ALL 3 pages</u> (including p. 3, MD Referral) must be received.***
- ***Only participants who can attend BOTH Tuesdays and Thursdays will be scheduled.***

***Thank you!***

Dear Healthcare Provider:

Your patient has requested to participate in the University of Puget Sound's School of Occupational Therapy Teaching Clinic. Participants volunteering for the teaching clinic work with an occupational therapy student, who is learning the process of evaluation and intervention, under the supervision of a licensed occupational therapist.

| **THIS SECTION MUST BE COMPLETED BY THE REFERRING PROVIDER** | | |
|---|---|---|
| Participant Name: | | |
| Address: | | Phone: |
| City: | State: | ZIP Code: |
| Referral Date: | Date of Onset/Injury: | |
| Medical Diagnosis: | | |
| Precautions: | | |
| Medications: | | |
| Reason for referral: | | |
| Comments: | | |
| **Provider Signature:** | | Date: |
| Provider name and address (please print or stamp): | | |
| Provider fax: | Provider phone: | |

## *Please return pages 1-3 of this referral form to:

**USPS mail:**
UPS School of Occupational Therapy
Teaching Clinic
1500 N. Warner St. #1070
Tacoma, WA 98416-1070

**FAX:** (253) 879-3518 or (253) 879-3540

***If you have questions, please call the school of OT at (253) 879-3514.***