REFERRAL

THE SPORTS CLINIC

+ PLEASE PRINT LEGIBLY OR PLACE A LABEL HERE +

Patient's Last Name: _____ Patient's First Name: _____

Date of Birth (YY/MM/DD): _____ Gender: ☐ Male ☐ Female

Health Card Number: _____ Home Phone: _____

Version Code: _____ Mobile Phone: _____

Address: _____ Business Phone: _____

_____ Email: _____

PLEASE CHECK IF APPLICABLE

☐ Sports Medicine Consultation ☐ Physio / Athletic Therapy ☐ Motor Vehicle Accident

☐ Chiropractic / ART Therapy ☐ Viscosupplementation / PRP ☐ Concussion (UTM Only)

☐ Massage Therapy ☐ Orthotics / Bracing ☐ Osteopathy

Area of Concern: _____

Working Diagnosis/ Medical History: _____

Relevant Imaging/ Reports: ☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ Bone Scan

Other: _____

REFERRING PHYSICIAN'S INFORMATION

Physician's Name & Billing number (print/stamp):

Name: _____ Signature: _____

Billing Number: _____ Date: _____

Phone: _____

Fax: _____

+ PLEASE FAX THIS FORM WHEN COMPLETED +

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