



DATE:

## PATIENT REFERRAL FORM

Please email this form to [bloordufferinrehab@gmail.com](mailto:bloordufferinrehab@gmail.com) or [activetherapyworks@gmail.com](mailto:activetherapyworks@gmail.com) and give a copy to the patient. Our representative from the Toronto Physio's head office will contact the patient to book an appointment at our clinic as per the patient's convenience and availability.

PATIENT NAME:

DOB:

PHONE:

ALTERNATE PHONE:

EMAIL:

ADDRESS:

CITY:

REFERRING DOCTOR:

OFFICE PHONE:

FAX:

FAMILY DOCTOR:

FAMILY DOCTOR PHONE:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Physiotherapy   | <input type="checkbox"/> Cupping           | <input type="checkbox"/> Spinal Decompression Therapy    | <input type="checkbox"/> Concussion Rehab       |
| <input type="checkbox"/> Chiropractic    | <input type="checkbox"/> Laser Therapy     | <input type="checkbox"/> Pulse Radio Frequency Treatment | <input type="checkbox"/> Exercise Rehab         |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Shockwave Therapy | <input type="checkbox"/> Motor Vehicle Accident Rehab    | <input type="checkbox"/> Chronic Pain Program   |
| <input type="checkbox"/> Acupuncture     | <input type="checkbox"/> Orthotics         | <input type="checkbox"/> Workplace Injury Rehab          | <input type="checkbox"/> Psychology/Counselling |

DIAGNOSIS:

Patient consent obtained to send emergency department medical record copy.

WSIB

EHC