ORTHOPAEDIC
REHABILITATION
INSTITUTE

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PATIENT REFERRAL FORM

☐ **URGENT** (SPECIFY REASON)

☐ **LOCATION:** (MUST SPECIFY)

PATIENT INFORMATION

PATIENT NAME

GENDER ☐ M ☐ F DATE OF BIRTH

ADDRESS

TEL

☐ MVA ☐ WSIB ☐ EHC ☐ PRIVATE ☐ OHIP
OHIP #:

REFERRING PHYSICIAN

PHYSICIAN NAME

ADDRESS

TEL FAX

BILLING NUMBER

CC FAMILY DOCTOR
(ENTER PHYSICIAN NAME IF APPLICABLE)

DIAGNOSIS

CLINICAL HISTORY

SPECIFIC CLINICAL QUESTIONS

CONSULTATION FOR THE FOLLOWING

- ☐ ORTHOPAEDIC CONSULTATION: ☐ SPINE ☐ LOWER EX. ☐ UPPER EX.
- ☐ CHRONIC PAIN CONSULTATION
- ☐ PHYSIATRY CONSULTATION
- ☐ RHEUMATOLOGY CONSULTATION
- ☐ SPORTS INJURY / MSK MEDICINE
- ☐ PROCEDURAL MEDICINE / INJECTION
- ☐ PAIN MANAGEMENT PLANNING
- ☐ NARCOTIC REDUCTION AND PAIN TRANSITION PROGRAM
- ☐ RETURN TO PLAY MANAGEMENT / TESTING
- ☐ PRE-OPERATIVE PHYSICAL THERAPY ASSESSMENT
- ☐ POST-OPERATIVE PHYSICAL THERAPY
- ☐ PHYSIO TRAINING SESSION & PROTOCOL DEVELOPMENT
- ☐ MULTIDISCIPLINARY REHABILITATION PROGRAM (specify protocol below)
- ☐ COMPLEX TRAUMA
- ☐ BONE STIMULATOR
- ☐ GAME READY
- ☐ ORTHOTICS
- ☐ BRACE: ☐ HINGE ☐ EXTENSION ☐ CUSTOM ☐ OTHER

TREATMENT PROTOCOL

☐ ACUTE JOINT PAIN ☐ ACUTE SPINE PAIN ☐ CHRONIC MSK PAIN ☐ NEUROPATHIC PAIN ☐ FIBROMYALGIA INFUSION THERAPY ☐ OTHER

SUPPORTING INFORMATION

To assist in timely and accurate care, include the following information and/or select and attach all the supporting documents that apply.

CURRENT MEDICATIONS

INVESTIGATIONS TO-DATE

- ☐ X-RAYS
- ☐ CT SCANS
- ☐ MRI SCANS
- ☐ BONE SCANS
- ☐ RECENT BLOOD WORK (INCLUDING CREATININE)
- ☐ OTHER

SPECIALIST CONSULT NOTES

- ☐ NEUROLOGY
- ☐ ORTHOPAEDICS
- ☐ RHEUMATOLOGY
- ☐ PHYSIATRY
- ☐ NEUROSURGERY
- ☐ PSYCHIATRY
- ☐ CHRONIC PAIN
- ☐ OTHER

PHYSICIAN SIGNATURE

DATE

☐ CLICK TO ACKNOWLEDGE YOUR CONSENT

I give my consent to release my personal contact and health information to the Orthopaedic Rehabilitation Institute for the provision of the above-mentioned treatment and services.

PATIENT'S SIGNATURE