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

☐ CHRONIC PAIN CONSULTATION: ☐ SPINE ☐ LOWER EX. ☐ UPPER EX.
☐ SPORTS INJURY / MSK MEDICINE
☐ SPECIFIC PROCEDURE
☐ PAIN MANAGEMENT PLANNING
☐ 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)
☐ BONE STIMULATOR
☐ GAME READY
☐ ASSESSMENT FOR BRACING
☐ BRACES & SPLINTS: ☐ UPPER EXTREMITY ☐ LOWER EXTREMITY

PRIOR TREATMENT

☐ INJECTION ☐ INFUSION ☐ MEDS

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