Referral

PhysioSportMed of Oakville
231 Oak Park Blvd, Suite 104
Oakville, ON, L6H 7S8

Tel: 905.257.3456
Fax: 905.257.2220

www.physiosportmed.ca

Please print legibly or place a label here

Patient's last name:	**Patient's first name:**	**DOB (DD/MM/YY):** **Gender:** ☐ Male ☐ Female
Health Card Number: **Version code:**	**Phone numbers:** Home: Business: Mobile:	**Address:**

Please Check if Applicable:

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

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

☐ Massage Therapy ☐ Orthotics / Bracing ☐ Osteopathy (WPO/UTM)

Area of Concern	
Working Diagnosis/ Medical History	
Relevant Imaging/ Reports	** If applicable, please fax the relevant reports along with this referral ** ☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ Bone Scan Other:

Referring Physician's Information: Please indicate as Applicable: FHO ☐ FHT ☐

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

** TO EXPEDITE THE PROCESS, PLEASE **FAX** THIS FORM TO 905 257-2220
AND HAVE YOUR PATIENT **CALL** US TO MAKE AN APPOINTMENT**