TRIANGLE PHYSIOTHERAPY

2501 Prince Michael Drive, Unit 2, Oakville L6H 0E9 Phone: 905.257.3334
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Sports Medicine Consultation Referral

Date: _____

Referring Physician: _____

Telephone Number: _____

OHIP Provider #: _____

Signature: _____

Patient's Name: _____

Date of Birth: _____

Telephone Number: _____

OHIP #: _____

Ver Code: _____ **Expiry Date:** _____

How did you hear about us? (Mark all that apply.)

☐ Referral Package from Clinic ☐ Google search ☐ Sign Board ☐ Patient

☐ Other: _____

Details

Priority ☐ Urgent ☐ Routine **Date of Injury:** _____ Activity/Sport affected: _____

Nature of Injury ☐ Acute (less than 4 weeks) ☐ Sub-acute (less than 3 months) ☐ Chronic

Part of the Body

☐ Shoulder/Arm ☐ Elbow/Forearm ☐ Wrist ☐ Hip/Pelvis ☐ Knee/Leg ☐ Foot/Ankle

☐ **Spine** ☐ Cervical ☐ Thoracic ☐ Lumbar

Reason for Referral

_____

_____

_____

Investigation Reports Attached

☐ Ultrasound ☐ X-Ray ☐ MRI ☐ CT ☐ EMG ☐ N/A

Please fax completed referral forms to: 905.257.3347 or Email: appointments@trianglephysiotherapy.com