



QUINTE PHYSIOTHERAPY CLINIC

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Date: _____ Sex ☐ M ☐ F

Patient Name: _____

Date of Birth: _____

Phone: _____ Work: _____

Referral Information:

☐ OHIP ☐ EHC ☐ WSIB ☐ PRIVATE ☐ MVA

Diagnosis: _____

Clinical Information: _____

Precautions/Contraindications: _____

Referral For:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Physiotherapy Rehabilitation | <input type="checkbox"/> Chiropractic Treatment | <input type="checkbox"/> Compression Stockings | <input type="checkbox"/> Chiropody (Foot Specialist) |
| <input type="checkbox"/> Pelvic Floor Physiotherapy | <input type="checkbox"/> Vestibular Physiotherapy | <input type="checkbox"/> 20-30 mm Mg | <input type="checkbox"/> TENS Unit |
| <input type="checkbox"/> 30-40 mm Mg | | | |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Orthotics/Orthopedic Shoes | <input type="checkbox"/> Home Assessment | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Braces/Splints | <input type="checkbox"/> Knee | <input type="checkbox"/> Wrist | <input type="checkbox"/> Lumbar |
| | <input type="checkbox"/> Ankle | <input type="checkbox"/> Elbow | <input type="checkbox"/> Other |
| <input type="checkbox"/> Registered Dietician | | <input type="checkbox"/> Mental Health Therapy | |

Referral By:

☐ Physician ☐ Nurse Practitioner ☐ Specialist ☐ Other

Name: _____

Billing #: _____

Phone #: _____ Fax #: _____

Address: _____

Signature: _____

STAMP

WE ACCEPT ALL INSURANCE PLANS & OFFER DIRECT BILLING