



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"/> Massage Therapy	<input type="checkbox"/> Orthotics/Orthopedic Shoes	<input type="checkbox"/> 30-40 mm Mg	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Braces/ Splints 	<input type="checkbox"/> Knee	<input type="checkbox"/> Home Assessment	<input type="checkbox"/> Lumbar
	<input type="checkbox"/> Ankle	<input type="checkbox"/> Wrist	<input type="checkbox"/> Other
<input type="checkbox"/> Registered Dietician		<input type="checkbox"/> Elbow	
		<input type="checkbox"/> Mental Health Therapy	

Referral By:

Physician Nurse Practitioner Specialist Other

Name: _____

Billing #: _____

Phone #: _____ Fax #: _____

Address: _____

Signature: _____

STAMP