Physiotherapy & Rehabilitation Outpatient Service Referral

***** Please write <u>clearly</u> and include medication reconciliation form as to avoid delay in scheduling appointments.**
All referrals require ICD-9/ 10 codes to be processed.* Thank you. **

Patient aware of referral: □ yes □ no   Next appointment with referring physician/ provider: dd/mmm/yyyy

Patient Name + Date of Birth [contact person name as appropriate]   Working Telephone Number/s

____   ____

____   ____

Patient Insurance: □ yes □ no   □ Argus □ BF&M □ Colonial □ GEHI □ Future Care □ HIP

Reason for referral/Diagnosis/ICD-9 Code(s): (*tick all that apply*)

PRIMARY DIAGNOSIS	Date (dd/mmm/yyyy)	*ICD-9/ 10 Code
□ ________________________	______________	________
□ ________________________	______________	________
SECONDARY DIAGNOSIS/ COMORBIDITY		
□ ________________________	______________	________
□ ________________________	______________	________

□ Other Past Medical History: ____

____

□ Surgical History: ____

____

□ Medication List ____

□ X Ray/ MRI results ____

□ Other investigation results ____

____

□ Recent labs attached

□ Patient most recent office visit records attached

Risk factors:

□ Smoking □ Diabetes □ High Blood Pressure □ Sedentary □ Weight Management □ High Cholesterol
□ Family History □ Medication non-compliance □ Hypoglycemic episodes □ Recent hospital admission
□ Recent Fall/s □ Other ____

____________________	______________________________	______________________________
Date (dd/mmm/yyyy)	**Physician/ Provider Printed Name**	**Physician's Signature**

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Evolution Healing Centre