REFERRAL FORM

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206-3333 Bayview Avenue
Willowdale, ON
M2K 1G4

Patient Information:

Date of Referral: _____

Name: _____

Phone: _____

Diagnosis / Contraindications / Comments:

_____

_____

_____

☐ As per discretion of the treating practitioner

Treatment Required:

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Exercise Therapy
- ☐ Acupuncture
- ☐ Manual Therapy
- ☐ Traction
- ☐ In-Home Physiotherapy
- ☐ TMJ Rehabilitation
- ☐ Sports Rehabilitation
- ☐ Customized Orthotics
- ☐ Assistive Devices & Braces
- ☐ Taping
- ☐ Pelvic Health Physiotherapy
- ☐ Vestibular Rehabilitation

Physician Information:

Referring Physician: _____ Phone: _____

Signature: _____

Billing Number: _____

Thank You