

Patient's name: _____

Date of birth: _____

Telephone number: _____

Date: _____

Reason for referral: _____

OHIP SERVICES

Sports medicine and/or MSK consultations

First available

Dr. Bazmi

Investigations Attached:

MRI

Ultrasound

CT

Bone Scan

X-ray

REHABILITATION SERVICES

Acupuncture

ART

Customized Injury Prevention

Dry Needling

Golf Injury Prevention

Manual Therapy

Shockwave Therapy

Personal Training

Physiotherapy (Orthopaedic)

Physiotherapy (Pelvic Health)

Physiotherapy (Vestibular)

Sports Specific Training Program

Sports Taping

PRODUCTS

Custom Knee Brace

REFERRING PHYSICIAN'S INFORMATION

Physician's name: _____

Signature: _____

Provider number: _____

Please fax completed form to:

647 349 4866

Empowering through movement