

PATIENT INFORMATION

Patient's name:
Date of Birth:
Health Card Number:
Phone Number:
Email:

Date: _____

Reason for Referral:

OHIP SERVICES

Sports Medicine and/or MSK consultation

First available Dr. Bazmi

Investigations Attached

MRI Ultrasound CT Bone Scan X-ray

REHABILITATION SERVICES

- | | |
|--|--|
| <input type="radio"/> Acupuncture | <input type="radio"/> Personal Training |
| <input type="radio"/> ART | <input type="radio"/> Physiotherapy (Orthopaedic) |
| <input type="radio"/> Customized Injury Prevention | <input type="radio"/> Physiotherapy (Pelvic Health) |
| <input type="radio"/> Dry Needling | <input type="radio"/> Physiotherapy (Vestibular) |
| <input type="radio"/> Golf Injury Prevention | <input type="radio"/> Sports Specific Training Program |
| <input type="radio"/> Manual Therapy | <input type="radio"/> Sports Taping |

PRODUCTS

Custom Knee Brace

REFERRING PHYSICIAN'S INFORMATION

Physician's name: _____

Signature: _____

Billing number: _____

Please fax completed form to:

647-349-4866

EMPOWERING THROUGH MOVEMENT

