

PHYSIOTHERAPY REFERRAL FORM

Referral Date:

Patient's Name:

Patient's D.O.B.:

Patients Phone#:

Diagnosis:

Other pertinent health information:

Condition: Acute Sub-Acute Chronic

Name of Family Physician:

Name of Referral Source:

Signature: _____ Phone Number:

Note that patients referred to PT services must:

- *be aged 20-64 with no access to extended health insurance for PT services*
- *not be seeking treatment for an injury insured through WSIB or MVA*
- *not qualify for a publicly funded Community Physiotherapy Clinic*

