

REFERRAL



+ PLEASE PRINT LEGIBLY OR PLACE A LABEL HERE +

Patient's Last Name: _____ Patient's First Name: _____
Date of Birth (YY/MM/DD): _____ Gender: Male Female
Health Card Number: _____ Home Phone: _____
Version Code: _____ Mobile Phone: _____
Address: _____ Business Phone: _____
_____ Email: _____

PLEASE CHECK IF APPLICABLE

- | | | |
|---|---|---|
| <input type="checkbox"/> Sports Medicine Consultation | <input type="checkbox"/> Physio / Athletic Therapy | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Chiropractic / ART Therapy | <input type="checkbox"/> Viscosupplementation / PRP | <input type="checkbox"/> Concussion (UTM Only) |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Orthotics / Bracing | <input type="checkbox"/> Osteopathy |

Area of Concern: _____

Working Diagnosis/ Medical History: _____

Relevant Imaging/ Reports: X-ray Ultrasound MRI CT Bone Scan

Other: _____

REFERRING PHYSICIAN'S INFORMATION

Physician's Name & Billing number (print/stamp):

Name: _____ Signature: _____

Billing Number: _____ Date: _____

Phone: _____

Fax: _____

+ PLEASE FAX THIS FORM TO THE PREFERRED LOCATION +

The Sports Clinic at U of T Mississauga
Recreation, Athletic and Wellness Centre
3359 Mississauga Road N
Mississauga, ON L5L 1C6
T: (905) 820-9292
F:(905) 820-9250

The Sports Clinic at Winston Park
Winston Park Medical Centre
2315 Bristol Circle
Oakville, ON L6H 6P8
T: (905) 829-2827
F:(905) 829-2831