PHYSIOTHERAPY
& REHABILITATION

PRIMARY HEALTHCARE FOR INJURY RECOVERY

PHYSIOTHERAPY
OCCUPATIONAL THERAPY
MASSAGE THERAPY
DIZZINESS CLINIC
CONCUSSION REHAB
NEURO THERAPY - BRAIN & STROKE
MEDICAL DRIVING ASSESSMENTS

REFERRAL FORM

Client Information

Client Name: ______________________ Date of Birth: ______________________

Address: ____

Contact No. ☎: ______________________ Injury related to: ☐ MVA ☐ WSIB ☐ Other

Service(s) Required

☐ Physiotherapy ☐ Occupational Therapy ☐ Dizziness Clinic ☐ Driving Evaluation

☐ Massage Therapy ☐ Concussion Rehab ☐ Custom Bracing ☐ Custom Splinting

Diagnosis/Comments/Precautions: ______________________________________

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Physician / Nurse Practitioner Information

Physician/NP Name: ______________________ Signature: ______________________

Address: ____

Contact No. ☎: ______________________ Fax: ______________________

Date of Referral: ______________________

Please complete for Driving Referral only

Primary Diagnosis: ____

Any history of seizures? ☐ Yes ☐ No If yes, please explain ______________________

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Will this patient's medications affect their ability to operate a motor vehicle? ☐ Yes ☐ No

To your knowledge, has this patient's driver's license been medically suspended? ☐ Yes ☐ No

It is **my opinion** that this patient is **medically stable to participate** in a Driver Evaluation:

☐ Yes ☐ No

Additional Comments: ____

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