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Sports Medicine Consultation Referral Form

Sports Medicine Physician Consultation:

- ☐ Bloor Street West Clinic
- ☐ Bay Street Clinic

Referring Physician:

Name:

Address:

Tel:
Fax:

OHIP Billing #:

Patient Name (Last, First):

DOB:

Health Card Number:

Address:

Telephone Number(s)

Reason for Referral (please print):

Mechanism of Injury (please specify):

Date of Onset/Injury:

Investigations Results (Patient to bring CDs of X-rays/MRI if already completed)

Signature:

Date: