ELITE PERFORMANCE & INJURY CENTRE
SPORT MEDICINE CLINIC PATIENT REFERRAL FORM

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info@epicsportsmedicine.ca

Type of Referral: ☐ Sport Medicine ☐ Physiotherapy
☐ Chiropractor ☐ Registered Massage Therapy

Patient Information:

Name:_____ Date of Birth: _____
DD/MM/YYYY

Address:_____ City/Town: _____ Province: __

Postal Code: _____ Health Card Number: _____

Phone: (_____)_____-_____ Email: _____

Is the injury related to WSIB, MVA or Litigation case? ☐ Yes ☐ No

*** If YES, please be aware we DO NOT see WSIB, MVA or litigation cases ***

Reason for Referral (Please include mechanism of injury, symptoms and timelines, past injuries):

Is the injury: ☐ Acute ☐ Acute on chronic ☐ Chronic

What sport/activity is the patient involved in?

Imaging related to injury: (Please attach reports) ☐ X-ray ☐ Ultrasound ☐ CT/MRI

Treatments to date (therapy, injection, consultation with other specialists – please attach reports):

If your referral is for multiple MSK complaints that are unrelated, we will need to schedule separate appointment to ensure appropriate time and management are offered for each complaint.

Referring MD/NP Name (please print): _____ OHIP #: _____

Signature: _____ ☐ FHO/FHN Date: _____
DD/MM/YYYY

Office Telephone: _____ Office Fax: _____

**Our physician has focused practice designation.