REBALANCE
SPORTS MEDICINE
rebalancetoronto.com

PATIENT REFERRAL FORM

Patient Name: _____

Daytime Phone: _____ **Date:** _____

Referral For:

- ❑ Sports Medicine Physician
- ❑ Physiotherapy
- ❑ Chiropractic & ART®
- ❑ Registered Massage Therapy
- ❑ Acupuncture
- ❑ Orthotics
- ❑ Bracing
- ❑ Personal Training
- ❑ Clinical Pilates
- ❑ Shockwave Therapy
- ❑ Pre and Post Operative Rehabilitation
- ❑ Other _____

Reason for Referral / Working DX:

X-Ray/Lab Reports:

Recommendations, Precautions & Comments:

Referring Physician: _____

Physician Signature: _____ **Physician No:** _____