REFERRAL FORM

Please fax this completed referral and all relevant medical reports to ***519-904-0658***

PATIENT INFORMATION	
Name:	Date of Birth:
Health Card Number:	
Street Address:	
City:	Postal Code:
Home Phone Number:	Work/Cell Phone Number:
Alternative Contact: (If necessary)	Relationship:
Home Phone Number:	Work/Cell Phone Number:
Diagnosis/Medical History: *If Spinal Cord Injury*: Level ____ Complete Incomplete Date of Injury/Event: _____	
Does the patient require a mechanical lift to transfer: yes no	

REFERRAL INFORMATION:	
Primary Care Provider:	Billing No.:
Phone Number:	Fax Number:
Referral Source (if different) :	
Reason for Referral:	

Issues to address:

- General assessment
- Preventative Care (Pap, bone health, immunizations etc.)
- Bowel/Bladder
- Spasticity
- Automatic Dysreflexia
- Pain
- Skin breakdown/wounds
- Medications
- Wheelchair/equipment
- Other: _____

_____

Depending upon patient needs, and clinic availability, patients will be triaged to one of two locations:

CFFM Mobility Clinic
250 Laurelwood Drive, Suite 4111
Waterloo, Ontario N2J 0E2

Andrew Street Mobility Clinic
16 Andrew Street
Kitchener, Ontario N2H 5R2