OAKVILLE PHYSIATRY

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MSK/Physiatry Consult Requisition

PATIENT INFORMATION

Full Name: _____

D.O.B.: ___/___/_____ (mm/dd/yyyy) Gender: ( ) M ( ) F ( ) Other: _____

Health Card: _____

Address: _____

_____

Phone (H): _____ Phone (C): _____ Phone (W): _____

HISTORY

_____

WSIB ( ) Claim #: _____ MVA ( ) Date of MVA: _____

REASON FOR REFERRAL

( ) MSK/Physiatry Consultation ( ) NCS/EMG & Consultation ( ) U/S Guided Injection

_____

Has any Diagnostic Imaging been completed? ( ) Yes ( ) No ( ) Ordered

( ) X-RAY ( ) U/S ( ) MRI ( ) CT ( ) Other: _____

Referring Physician: _____

Referring Physician Signature: _____

Billing #: _____ Date: ___/___/_____

PLEASE FAX SIGNED & COMPLETED FORMS TO: 905-842-5316

Patients will be booked with the first available physiatrist.