

Haliburton Highlands Health Services OUT-PATIENT PHYSIOTHERAPY REFERRAL

P.O. Box 115, Haliburton, ON, K0M 1S0 Telephone: 705-457-1392 (2226) Fax: 705-457-2398

NOTE: To ensure appropriate prioritization, thorough completion of this referral is required. Incomplete referrals may delay admission to therapy. PATIENT: Date of Birth: ____/__ Last dd/mm/yy ADDRESS: HEALTH CARD #: _____ EXPIRY DATE: ____ TELEPHONE: (______) ____-____ (h) (______) ____-___ (w) WSIB: □ MVA: REFERRING DIAGNOSIS: __ DATE OF ONSET/INJURY: ___/__ DATE OF SURGERY/PROCEDURE: __ dd/mm/yy dd/mm/yy Pending **Diagnostic Tests** Completed **Findings** X-ray US MRI CT Other (e.g. EMG) RELEVANT CLINICAL FINDINGS: RELEVANT MEDICAL HISTORY: (e.g. Diabetes, Heart Disease, CA) PLEASE INDICATE THE ACUITY OF THE CONDITION: (based on OBJECTIVE findings) (e.g. post-surgery, post-fracture, acute respiratory, recent CVA, acute sprain/strain) **ACUTE SUB-ACUTE** (e.g. rotator cuff injury, recent exacerbation of chronic condition, DDD exacerbation) **CHRONIC** (e.g. OA, residual deficits of previous stroke) **PLEASE NOTE**: Due to the high volume of referrals, wait times may be lengthy for patients with sub-acute and chronic conditions. We recommend that you also inform your client of other physiotherapy services in the community. Physician/Nurse Practitioner Name Signature Telephone Date

Last Revised December 2019

Physician's College Billing #

Physician's CPSO #