



REFERRAL FORM

Please fax this completed referral and all relevant medical reports to 519-578-2109

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:	
<i>If Spinal Cord Injury:</i> Level ____ <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete Date of Injury/Event: _____	
Does the patient require a mechanical lift to transfer: <input type="checkbox"/> yes <input type="checkbox"/> no	
REFERRAL INFORMATION:	
Primary Care Provider:	Billing No.:
Phone Number:	Fax Number:
Referral Source (if different) :	
Reason for Referral:	
Issues to address: <input type="checkbox"/> General assessment <input type="checkbox"/> Preventative Care (Pap, bone health, immunizations etc.) <input type="checkbox"/> Skin breakdown/wounds <input type="checkbox"/> Bowel/Bladder <input type="checkbox"/> Medications <input type="checkbox"/> Spasticity <input type="checkbox"/> Wheelchair/equipment <input type="checkbox"/> Automatic Dysreflexia <input type="checkbox"/> Other: _____ <input type="checkbox"/> Pain _____	

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