



Physiotherapy  
3560 Bathurst St., Main Floor, Toronto, ON M6A 2E1  
Telephone: (416) 784-3600 Fax: (416) 784-5600

REQUEST FOR CONSULTATION

PATIENT NAME: \_\_\_\_\_  
HEALTH CARD: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
PHONE: \_\_\_\_\_ WORK/CELL: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
PRIMARY CONTACT \_\_\_\_\_ PHONE: \_\_\_\_\_

Please check if any of these apply: Private Insurance  ODSP  WSIB  Veterans Affairs  MVA

REFERRING DR.: \_\_\_\_\_ BILLING # \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
TELEPHONE: ( ) \_\_\_\_\_ FAX: ( ) \_\_\_\_\_

DIAGNOSIS:  Stroke  MS  Movement Disorder  ALS  Other: \_\_\_\_\_

PROGRAM REQUESTED:

- Gait and Balance Training  Upper Extremity Program  Poling
- Technology Programs: (circle) Alter -G K-SRD Bioness Laser-Walk

REASON FOR REFERRAL: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SIGNIFICANT MEDICAL HISTORY (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*Please attach most recent medical report\*\*

CURRENT MEDICATIONS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Please Fax your referral and most recent medical report.

IMPORTANT NOTICE ON CONFIDENTIALITY:

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