GRAND RIVER HOSPITAL
Advancing Exceptional Care

PROSTHETIC AND ORTHOTIC CLINIC
Physical Medicine and Rehabilitation
Outpatient Referral Form

Freeport Campus, Pioneer Terrace 1st Floor
3570 King Street East, Kitchener, Ontario, N2A 2W1
Phone: 519-749-4300, ext. 7860 Fax: 519-894-8310

Patient's Last Name:	**Patient's First Name:**	**Initial:**	❑ **Male** ❑ **Female** ❑ **Other**_____
DOB (year/month/day):	**Health Card #:**	**Version Code:**	**WSIB Claim #:**
Street Address:	**City:**	**Province:**	**Postal Code:**
Patient's Phone:	**Cell Phone:**	**The patient consents to messages being left at this number ❑ Yes ❑ No**	

Assess For:

Please note that referral includes Physiotherapy assessment and treatment as indicated.

❑ **Orthosis** ❑ **Prosthesis**

Primary Diagnosis:

Secondary Diagnosis:

Comments:

To ensure the most appropriate intervention, please include relevant operative reports, consult notes, imaging results, and rehabilitation therapy reports (unless available through Clinical Connect).

Referring Physician Name (please print):	**Physician's Phone #:**	**Physician's Fax #:**
Physician's Signature:	**Physician's Billing #: (Required)**	