

**PROSTHETIC AND ORTHOTIC CLINIC**  
**Physical Medicine and Rehabilitation**  
**Outpatient Referral Form**

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

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

**Assess For:**

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

<input type="checkbox"/> Orthosis	<input type="checkbox"/> Prosthesis
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**Primary Diagnosis:**

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**Secondary Diagnosis:**

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**Comments:**

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

<b>Referring Physician Name (please print):</b>	<b>Physician's Phone #:</b>	<b>Physician's Fax #:</b>
<b>Physician's Signature:</b>	<b>Physician's Billing #: (Required)</b>	