The Centre For Sport & Recreation Medicine

Patient Referral

Date: _____

Patient Name: _____

Patient Telelphone No.: _____

Reason For Referral:

- ☐ Acupuncture
- ☐ Athletic / Physiotherapy
- ☐ Chiropractic
- ☐ Compression Socks
- ☐ Custom/ Off-the-Shelf Bracing
- ☐ Massage Therapy
- ☐ Orthotics
- ☐ Prescribed Exercise Program
- ☐ Sport Medicine Physician
- ☐ Vestibular Rehabilitation
- ☐ Other: _____

Working Diagnostics/Comments:

Referring Physician Information

Name: _____

Physician No.: _____

Signature: _____

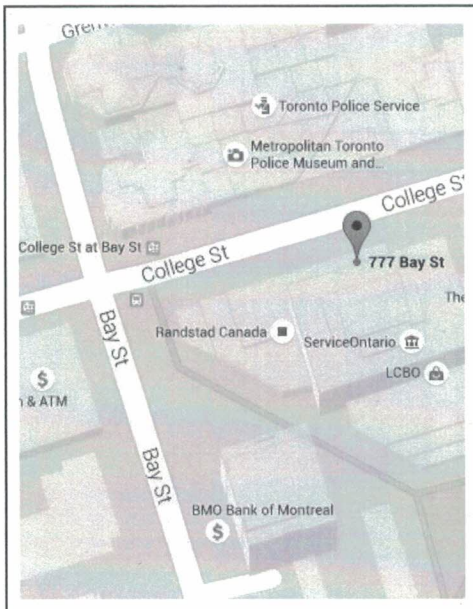
☐ Please send more referral pads.

Thank You For Your Referral

"You Don't Have To Be A Pro To Be Treated Like A Pro"

www.TorontoSportsMedicine.ca

Our Locations:



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THE CENTRE FOR SPORT & RECREATION MEDICINE

Thank You For Choosing
The Centre For Sport & Recreation Medicine

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