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## Referral Form

### Patient's Information

Last Name:	First Name:
Phone:	Email:
Diagnosis/Contra-Indication/Comments:	
Patient is: <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Work Related Injury (WSIB) <input type="checkbox"/> Extended Health Coverage	

### Treatments Required

<input type="checkbox"/> Physiotherapy Treatment <input type="checkbox"/> Pelvic Floor Physiotherapy <input type="checkbox"/> Shockwave Therapy <input type="checkbox"/> Chiropractic Treatment <input type="checkbox"/> Acupuncture Treatment <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Athletic Therapy	<input type="checkbox"/> Spinal Decompression <input type="checkbox"/> Custom Made Orthotics <input type="checkbox"/> Compression Stocking <input type="checkbox"/> Custom Made Brace <input type="checkbox"/> Post-Surgical Rehabilitation <input type="checkbox"/> Work Conditioning Program <input type="checkbox"/> Psychotherapy/ Social Work
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### Physician Information

Referring Physician:	
Phone Number:	Date:
Signature:	

Thank you for the referral.  
 To make your appointment please call 289-466-1140