

LinkWITHWork

OBJECTIVE ASSESSMENTS, CONSULTATION AND EFFECTIVE TREATMENT
Program of Grand River Hospital

Physiotherapy Referral Form

Please note, items marked with an asterisk (*) are considered mandatory items

Client Information

*Name	_____	*Home Ph#	_____
Address	_____	Work Ph#	_____
	City _____	Postal Code	_____
*DOB m/d/y	_____	Age	_____
		Sex	Male { } Female { }
*WSIB Claim#	_____	SIN#	_____

Medical Information

Diagnosis:	_____		

*Date of Injury	yr mth day	Last Day Worked	yr mth day
{ } WSIB	{ } Off Work	{ } Regular Duties	{ } Auto Insurance
	{ } Working	{ } Modified Duties	{ } Extended Health
			{ } Employer pay
			{ } Self Pay
Employer & Contact Name	_____		

Contraindications or Restrictions

Contraindications or Restrictions:	_____

Practitioner Information

Physician Signature	_____	Phone	_____
		Fax#	_____
Physician Name (please print)	_____	Date	_____