KINATEX SPORTS PHYSIO

REFERRAL / PRESCRIPTION FORM

PATIENT'S NAME .....

PHONE NO. ..... **DATE OF BIRTH** .....

SERVICES

- ☐ Physiotherapy
- ☐ Chiropractic
- ☐ Chiropody (Foot Care)
- ☐ Sports Injury Assessment
- ☐ Post-Accident ASsessment (specify)
  - ☐ Motor Vehicle Accident (MVA)
  - ☐ Work Accident (WSIB)
  - ☐ Other
- ☐ Massage Therapy
- ☐ Acupuncture
- ☐ Dietitian
- ☐ Shock-wave Therapy
- ☐ Laser Therapy
- ☐ Traction Therapy
- ☐ Computerized Adjustment

PRODUCTS

- ☐ Custom-made Orthotics
- ☐ Compression Stockings / Socks
  - ☐ 20-30 mmHg
  - ☐ 30-40 mmHg
  - ☐ 40+ mmHg
- ☐ Orthopaedic Pillow
- ☐ T.E.N.S.
- ☐ Back Support
- ☐ Orthopaedic / Modified Footwear
- ☐ Custom-made Brace
  - ☐ Knee
  - ☐ Shoulder
- ☐ Off-the-shelf Brace (specify)
  - ☐ Type .....
- ☐ Posture Corrector
- ☐ Other Product .....

INSTRUCTIONS

- ☐ Progress Report Requested
- ☐ Urgent Appointment Requested
- ☐ Contraindications .....
- ☐ Other Notes .....

Diagnosis .....

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Signature ..... Physician's Name .....

Date .....

PHYSICIAN, PLEASE
IMPRINT YOUR STAMP HERE

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