



## REFERRAL/PRESCRIPTION FORM

PATIENT'S NAME .....

PHONE NO. ....

DATE OF BIRTH .....

### SERVICES

- |  |  |
|--|--|
| <input type="checkbox"/> Manual Therapy (Physiotherapy / Chiropractic / Massage Therapy / Acupuncture) | <input type="checkbox"/> Chiropody (Foot Care)       |
| <input type="checkbox"/> Dietitian   | <input type="checkbox"/> Psychology                  |
| <input type="checkbox"/> Exercise Program  | <input type="checkbox"/> Pelvic Floor Rehabilitation |

### PRODUCTS

- ☐ Compression Stockings / Socks (20-30mmHg / 30-40mmHg / 40+mmHg)
- ☐ Custom-made Orthotics
- ☐ Orthopedic Support / Brace
- ☐ Other .....

Diagnosis

Other notes

Signature .....

Date .....

Physician's Name .....

Physician's Phone No .....

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