168 Reynolds Walk
Guelph, ON N1G 2W1
Phone: 519-767-5011
Fax: 519-821-4007
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HPC SPORTS MEDICINE REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Health Card Number and Version Code: _____

Telephone Number: _____

Alternative Number: _____

REASON FOR REFERRAL

Injury/Area of Concern:

_____

Symptom Onset and Duration:

_____

Mechanism of Injury (if applicable):

_____

Sport and Physical Activity Participation:

_____

Previous Assessment and Treatment:

_____

IMPORTANT REFERRAL REQUIREMENTS

• **Relevant imaging reports must accompany all referrals**.

• Referrals with pending, outstanding, or ordered-but-not-yet-completed imaging will be declined and returned to the referring provider.

• Responsibility for ongoing patient management remains with the referring provider.

Attached IMAGING

☐ X-Ray

☐ Ultrasound

☐ MRI

☐ CT

☐ Other: _____

REFERRAL REVIEW

All referrals are reviewed by our Sports Medicine team prior to appointment booking. Submission of a referral does not guarantee acceptance. Our office will confirm acceptance of the referral before an appointment is offered. Incomplete referrals, referrals submitted without completed imaging, or referrals that do not meet clinic criteria may be returned to the referring provider.

REFERRING PROVIDER INFORMATION

Referring MD Name: _____

OHIP Billing Number: _____

Telephone Number: _____

Fax Number: _____

Address: _____

Signature: _____