Arbeau Sports Medicine Centre
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ARBEAU SPORTS MEDICINE CENTRE PATIENT REFERRAL FORM

Patient information:

Name: ____ Date of Birth: ________________

Address: ____

Contact Number: _____________________ Email: __________________________________

Health Card Number: ________________________ Version Code: ________________

Reason for referral:

Please include any previous treatment options, imaging and/or consultations for the referring injury/complaint

Is the injury/complaint:

Acute _______ Acute on Chronic _______ Chronic _______

Referring Physician/Nurse Practitioner:

-

Name: ___________________________________ OHIP Billing #: ____________________

Signature: ________________________________ Date of Referral: __________________

Office Telephone Number: ___________________ Office Fax Number: ________________

NOTE: Our physicians are FRCPC(EM) trained with focused practice designation in Sports Medicine therefore referrals will not affect any physicians with a rostered model practice.