

PHYSICAL THERAPY REFERRAL

PATIENT INFORMATION

FULL NAME _____

DATE OF BIRTH _____ HEALTH CARD # _____

PHONE _____ EMAIL _____

CLINICAL INFORMATION

DIAGNOSIS / PRESENTING CONDITION _____ DATE OF SURGERY (IF APPLICABLE) _____

WEIGHT-BEARING STATUS _____

PRECAUTIONS / RESTRICTIONS _____

MEDICAL IMAGING FINDINGS _____

UPLOAD IMAGING / CONSULT NOTES? Yes No

MEDICATIONS RELEVANT TO REHAB _____

REASON FOR REFERRAL

- | | |
|--|---------------------------------------|
| Pre-Surgical Rehabilitation | Post-Surgical Rehabilitation |
| Range of Motion Restoration | Progressive Strengthening |
| Acute Musculoskeletal Injury | Chronic Pain Management |
| Arthritis and Degenerative Joint Disease | Back and Neck Pain |
| Balance and Fall Prevention | Mobility Decline and Functional Rehab |
| Return to Work / Ergonomic Assessment | Acupuncture and Dry Needling |
| Other: _____ | |

ADDITIONAL NOTES

REFERRING PRACTITIONER

NAME _____ PROFESSION / TITLE _____

CLINIC / ORGANIZATION _____

PHONE _____ EMAIL _____

Patient aware of referral Patient to contact clinic directly

DATE OF REFERRAL _____

HOW TO REFER

Email: info@miladbazaz.com

Phone: 647-996-3469

Patients may also self-book at:
miladbazaz.com/contact

Physical therapy in Ontario is direct access.
Referral not required for assessment
unless required by insurer.



SCAN TO BOOK

SIGNATURE & PRACTITIONER STAMP

Click to type — or sign electronically