Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / *À l'écoute de notre santé*

Outpatient Physiotherapy Referral Form

★ PLEASE PRINT ★

Patient's Name: _____ **Date of Birth:** ____/____/____ (M / D / Y)

M.H.S.C. Number: _____ **P.H.I.N.:** _____

Address: _____

City: _____ **Province:** _____ **Postal Code:** _____

Phone: (Home) _____ (Work) _____ (Other) _____

Contact person if other than above: _____ **Phone:** _____

Reason for Referral / Diagnosis:

_____

_____

_____

Date of Onset: _____

Is this as a result of a work related injury or motor vehicle accident? ☐ Yes ☐ No

Medical conditions relevant to the reason for referral:

_____

_____

Name of Person Making the Referral: _____

Signature: _____

Mailing Address: _____

_____

Phone Number: _____

Date of Referral: _____

Please mail or fax to: **Physiotherapy Central Intake**
RR 132 – 800 Sherbrook Street
Winnipeg, Manitoba R3A 1M4
Fax: 787-1034

Office Use Only:
List:
Code:
Screened by:
Date Received: