GRACE HOSPITAL

Safe on Your Feet
Program Referral Form

★ PLEASE PRINT ★

Patient 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: _____

Date of Referral: _____

Referred by:

□Self

□Health Care Provider: _____

_____

Please attach if available (or provide score):

□ Physio assessment

□ OT assessment

□ DPIN

□ MMSE Score: _____

□ Hendrich II Score: _____

□ Other: _____

Comments: _____

_____

_____

_____

_____

_____

Please send to:

Grace Hospital Physiotherapy Department
300 Booth Drive
Winnipeg, MB R3J 3M7
Phone: 204-837-0208 Fax: 204-837-0520

Assessment Booked: