Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Outpatient Physiotherapy
Referral Form

★ PLEASE PRINT ★

Patient's Name: _____

Date of Birth: _____ **MHSC Number:** _____ **PHIN:** _____

Address: _____

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

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

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

Diagnosis: _____

Reason for Referral:

_____

_____

_____

Date of Onset: _____ ☐ **Acute** ☐ **Chronic** ☐ **Acute on Chronic**

Have you received any previous treatment and/or physiotherapy for this injury? ☐ **Yes** ☐ **No**

Is the need for treatment the result of a work related injury or motor vehicle accident? ☐ **Yes** ☐ **No**

Date of Surgery (if appropriate)**:** _____

Medical conditions and/or tests relevant to the reason for referral:

_____

_____

_____

Physician (please print full name): _____

Name of Person Making the Referral: _____

Signature: _____ **Designation:** _____

Mailing Address: _____

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

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 Phone: 787-1160

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