GOOD HOPE
sports medicine

**Sport Medicine Physican Referral Form – Fax completed form to: 780-900-0454**
To avoid delays, this form MUST be completed in full

- ○ Next Available Appointment
- ○ Urgent Appointment (will be reviewed)

PATIENT INFORMATION:

Name:_____ Gender: _____ DOB: _____ Age: _____
Address: _____
Phone Number: Home:_____ Cell:_____
PHN: _____

**Clinical Details:**
Injury Date: _____
Body Part: _____
Activity/Sport affected _____

- ❑ Acute Injury (< 4 weeks)
- ❑ Flare-up of Pre existing condition
- ❑ Chronic Condition

**Reason for Referral:** (Please include mechanism of injury, present symptoms, treatment to date, effect on individuals sport/exercise participation):

**Pertinent Past Medical History and Medications:**

Imaging and/or investigations are not necessary for patient referral. If imaging has been completed please indicate below and forward results to our office. If images are on Netcare, there is no need to send a disc.

- ❑ X-Ray
- ❑ CT
- ❑ Ultrasound
- ❑ MRI
- ❑ Bone Scan
- ❑ N/A

Referring Health Professional Information:
Name (Print): _____
Mailing Address: _____
_____
Fax Number: _____

PRAC ID: _____
Date: _____
Signature: _____
Phone number: _____

PIVOTAL PHYSIOTHERAPY
2002 Northgate Centre, 9499 - 137 Ave, Edmonton, AB T5E 5R8
p 780 473 1461 f 780 473 4344 e nancy@pivotalphysio.com