Chiromedics
HEALTH CENTRE

Referral / Requisition

☐ Dr. Galati ☐ Dr. Topos ☐ Dr. Dhotar

Patients Name: _____ Date: _____

Diagnosis: _____

Precautions (please specify) _____

_____

Patient Type ☐ MVA ☐ Extended Health ☐ W.S.I.B.

Treatment / Program

☐ Full Rehabilitation Program
(as appropriate, Physiotherapy, Chiropractic, Massage Therapy & Acupuncture)

☐ Physiotherapy

☐ Chiropractic

☐ Massage Therapy

☐ Acupuncture

☐ Other (please specify)

_____

☐ Braces / Splints
- •Knee
- •Ankle
- •Wrist
- •Lumbar
- •Elbow
- •Other (please specify)

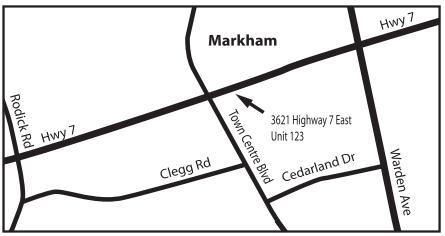
_____

☐ T.E.N.S. Unit

☐ In-Home / Worksite / Functional Assessment

Referring Physician: Dr . _____

Telephone: _____



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