FOWLER KENNEDY
stay active

3M Centre
Western University
London, ON N6A 3K7
Tel: 519-661-3011
FAX: 519-661-3379

Fanshawe College
Room J1004
London, ON N5Y 5R6
Tel: 519-452-4230
FAX: 519-452-4415

FOWLER KENNEDY SPORT MEDICINE CLINIC PATIENT REFERRAL FORM

Type/ Location of Referral: **Sport Medicine Physician**

- ☐ 3M Centre, Western
- ☐ Fanshawe College

Physiotherapy

- ☐ 3M Centre, Western
- ☐ Fanshawe College

Patient Information:

NAME:_____ Date of Birth:_____/____/_____
Day Month Year

Address:_____ City/Town:_____Province: _____

Postal code:_____ Best Contact Phone Number: _____

HC#: _____ Email: _____

Reason for Referral (Please include mechanism and date of injury):

Is the injury: ☐ **Acute** ☐ **Acute on chronic** ☐ **Chronic**

What Sport / Activity is the patient involved in?

Imaging related to injury; (Please attach reports) ☐ Xray ☐ Ultrasound ☐ CT/MRI

Treatments to date:

Is the injury related to WSIB, MVA patients or litigation cases ☐ **YES** ☐ **NO**
***** If YES, please be aware <u>we do not see</u> WSIB, MVA patients or litigation cases**

If the patient has **multiple MSK complaints** that are **unrelated,** please consider referring each issue **separately**. This is to ensure appropriate amount of time is taken for each issue in consultation.

Referring Physician Name (please print):_____**OHIP #** : _____

Signature:_____ ☐ **FHO/FHN** ☐ **FFS** Date:_____/____/_____
Day Month Year

Office Telephone:_____ Office Fax: _____

****Majority of our physicians have GP focused practice designation. If you are a rostered model practice,* ***WE'LL DO OUR BEST*** *to book your patient with one of our focused practice designated physicians.*