3M Centre
Western University
London, ON N6A 3K7

FOWLER KENNEDY SPORT MEDICINE CLINIC PATIENT REFERRAL FORM

Type / Location of Referral: **Orthopaedic Surgeons**

- ☐ Dr. Getgood - Knee, Phone: 519-661-4003 **Fax: 519-850-2991**. Accepts all physician referrals
- ☐ Dr. Willits - Shoulder, Hip, Knee and Ankle, Phone: 519-661-4121 **Fax: 519-850-2484**. Accepts all physician referrals
- ☐ Dr. Litchfield - Shoulder and knee, Phone: 519-661-4156 **Fax: 519-850-2497.** Accepts referrals by specialist only
- ☐ Dr. Giffin - Knee, Phone: 519-661-3454 and **Fax: 519-850-2496**. Accepts referrals by specialists only
- ☐ Dr. Degen - Shoulder, Hip, Knee, Phone: 519-661-2171 and **Fax: 519-661-4237**. Accepts all physician referrals

Patient Information:

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

Address: _____ City/Town: _____ Province: _____

Postal code: _____ Best Contact Phone Number: _____

HC#: _____ Email: _____

Reason for Referral:

Referring Physician Please Note:

- Please attach any relevant imaging reports and previous surgical reports (if applicable)

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

Signature: _____ Date: _____ /____ /_____
Day Month Year

Office Telephone: _____ Office Fax: _____

Address: _____ Postal Code: _____