FOWLER KENNEDY
stay active

Western University
3M Centre
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

South Clinic
3209 Wonderland Rd. S
London, ON N6L 1R4
Tel: 226-667-3338
Fax: 866-389-4559

FOWLER KENNEDY SPORT MEDICINE CLINIC PATIENT REFERRAL FORM

Type/Location of Referral:

Sport Medicine Referral
- ☐ Western, 3M Centre
- ☐ Fanshawe College
- ☐ South Clinic

Physiotherapy
- ☐ Western, 3M Centre
- ☐ Fanshawe College
- ☐ South Clinic

Patient Information:

Name: _____ Date of Birth: _____
DD/MM/YYYY

Address: _____ City/Town: _____ Province: _____

Postal Code: _____ Health Card Number: _____

Home Phone: _____ Preferred ☐ Cell Phone: _____ Preferred ☐

Email: _____

Is the injury related to WSIB, MVA or Litigation case? Yes ☐ No ☐
***** If YES, please be aware we DO NOT see WSIB, MVA or litigation cases *****

Reason for Referral (Please include mechanism of injury, symptoms and their timelines, past injuries):

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

What sport/activity is the patient involved in?

Imaging related to injury: (Please attach reports) ☐ X-ray ☐ Ultrasound ☐ CT/MRI

Treatments to date (therapy, injection, consultation with other specialists – please attach reports):

If your referral is **for multiple MSK complaints** that are **unrelated**, we may need to schedule **separate appointment** to ensure appropriate time and management are offered for each complaint.

Referring MD/NP Name (please print): _____ OHIP #: _____

Signature: _____ ☐ FHO/FHN Date: _____
DD/MM/YYYY

Office Telephone: _____ Office Fax: _____

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