



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: 1-866-389-4556

### 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\*\***