3M Centre
Western University
London, Ontario
N6A 3K7

FOWLER KENNEDY SPORT MEDICINE CLINIC REFERRAL FORM – ORTHOPAEDIC SURGEONS

Please select **ONE** surgeon and fax directly to their office.

- ☐ Dr. Willits - **Shoulder, Hip, Knee and Ankle**, Phone: 519-661-4121 **Fax: 519-850-2484**
- ☐ Dr. Degen - **Shoulder, Hip and Knee**, Phone: 519-661-2171 and **Fax: 519-661-4237**
- ☐ Dr. Litchfield - **Shoulder and Knee**, Phone: 519-661-4156 **Fax: 519-850-2497**
- ☐ Dr. Giffin - **Knee**, Phone: 519-661-3454 and **Fax: 519-850-2496**

Patient Information:

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

Address: _____ City/Town: _____ Province: _____

Postal code: _____ Best Contact Phone Number: _____

Health Card #:_____VC:_____ Email:_____

Reason for Referral: (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: _____