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** (NOT CURRENTLY ACCEPTING REFERRALS)

Dr. Giffin – **Knee** (NOT CURRENTLY ACCEPTING REFERRALS)

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: _____