



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. Nakanishi - **Knee**, Phone: 519-661-4003 Fax: **519-850-2991**
- 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: _____