Healthcare Management Group

Physician Referral Form

Patient's Name: _____

Tel No: _____ Date: _____

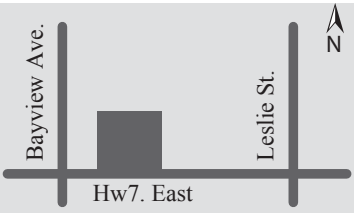
R_x:

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Osteopathy Therapy
- ☐ Acupuncture
- ☐ Chiropractic/Manual Medicine
- ☐ Psychological Counselling
- ☐ Chronic Pain Program
- ☐ Shockwave Therapy
- ☐ Decompression Therapy
- ☐ Cold Laser Therapy
- ☐ Orthopaedic products
- ☐ Assessments

☐ MVA ☐ WSIB ☐ Slip & Fall ☐ EHC ☐ OW/ODSP/Refugee

D_x:

Comments:



Signature / Stamp: _____

330 Hwy 7 East, Suite 303
Richmond Hill, Ontario L4B 3P8

Tel: 905.882.1006
Fax: 905.882.1007