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❑ **URGENT**

PM&R Consultation & Procedures Requisition

Surname: _____

Given Names: _____

Address: _____

City: _____ Postal Code:_____

OHIP No.: _____ VC: ___

Phone: _____ Cell: _____

Date of Birth (MM/DD/YYYY): _____

WSIB #.: _____ Date of Injury: _____

Gender: M ❑ F ❑ UK ❑

Family Physician: _____

Referring Physician: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Fax: _____

OHIP Billing # _____

Anatomical Area ☑ (New OHIP directive limits 1 area per requisition)

Shoulder	L ☐	R ☐	Hip	L ☐	R ☐
Arm	L ☐	R ☐	Thigh	L ☐	R ☐
Elbow	L ☐	R ☐	Knee	L ☐	R ☐
Wrist	L ☐	R ☐	Leg	L ☐	R ☐
Hand	L ☐	R ☐	Ankle	L ☐	R ☐
Fingers	L ☐	R ☐	Foot	L ☐	R ☐

NOTE : <u>All</u> joint-related referrals <u>must</u> be accompanied by relevant imaging.
(knee x-rays should be standing)

Working Diagnosis or Complaints:

Further Information:

Anticoagulants? ☐ **Y** **DM?** ☐ **Y** **AIDS/HepC?** ☐ **Y** **Allergy?** ☐ **Y:**_____

_____ Authorized Signature

_____ Date