LEGACIES HEALTH CENTRE

Referral Date		WSBC Information (if applicable)			
		Claim #		DOI	

Sports Medicine Consultation – Physician Referral Form

Patient Information (or affix label)		Referring Physician Information	
First/Last Name		Ref. Physician Name	
PHN		MSP #	
DOB		Address	
Age		Phone	
Gender		Fax	
Cellphone		Family Physician (if different from referring Physician)	
Email			

Patient's cellphone and email are required, as they will receive a questionnaire to complete prior to the appointment.

Reason for Referral

Body Region

☐ Shoulder/ Arm	☐ Elbow/ Forearm	☐ Wrist	☐ Hand/ Fingers
☐ Hip/ Pelvis	☐ Knee/ Leg	☐ Foot/ Ankle	
☐ Other, provide details:			

Relevant History

Diagnosis and Treatment to Date (please include HPI, PMHx/ surgical Hx, medications or attach documents		☐ Letter Attached
Current Medications		☐ Attached
Allergies		☐ Attached

X-Ray Requirement (All Patients require medical imaging for triage)

Have x-rays of the affected area been obtained?	☐ Yes, reports attached	☐ No		
Additional Imaging	☐ Ultrasound	☐ CT	☐ MRI	☐ Nuclear Med

Please fax the completed form and required supporting documentation to 778-730-0169.