

**SPORT MEDICINE PHYSICIAN ASSESSMENTS – FAX TO (780) 460 – 9978**

**Patient Information (May use label)**

Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Prov: \_\_\_\_\_ PC: \_\_\_\_\_  
 D.O.B.: \_\_\_\_\_ PHC#: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Daytime: \_\_\_\_\_  
 Email: \_\_\_\_\_

**Referral Clinic Information**

Clinician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 PH#: \_\_\_\_\_ Fax# \_\_\_\_\_  
 Email: \_\_\_\_\_  
 PRACID: \_\_\_\_\_

**PHYSICIAN SERVICE(S) REQUESTED**

- Sport Medicine Consult (Acute)
- Sport Medicine Consult (>3 months)
- Pediatric Sport Medicine (Acute)
- Pediatric Sport Medicine (Chronic)
- Sport Concussion Clinic (< 3 months)
- Concussion Clinic (<12 months)
- Acute Spine Assessment

**PHYSIOTHERAPY SERVICE(S) REQUESTED**

- Physiotherapy
- Concussion/Vestibular Therapy
- Pelvic Health
- Occupational Therapy - Hand Therapy/Splinting
- Occupational Therapy - Cognitive/Concussion
- Massage Therapy
- WCB Assessment

**Clinical Concern(s) - ✓ all relevant concerns**

- |   |   |
|---|---|
| <input type="checkbox"/> Sport Injury<br>Body part: _____ | <input type="checkbox"/> Concussion           |
| <input type="checkbox"/> Neck Pain                        | <input type="checkbox"/> Arthritis Management |
| <input type="checkbox"/> Back Pain                        | <input type="checkbox"/> Joint Pain           |
| <input type="checkbox"/> Other: _____                     | Joint: _____                                  |

**Subjective/Objective Findings**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Investigations/Consultant Reports:** *(Please attach all reports, medications & past medical history)*

**Sport Medicine & Physiatry Partners**

Dr. Dhiren Naidu  
 Dr. John Clarke  
 Dr. Curtis Hlushak

Dr. Boris Boyko  
 Dr. Shelby Karpman  
 Dr. Adam Keough

Dr. Shane Hoerber  
 Dr. Darren Gray  
 Dr. Erika Persson (Peds)