ACTIVE MEDICINE TORONTO

Referral Request

Referral Date:	

135 Yorkville Avenue, 2nd Floor, Toronto, Ontario, M5R 3N5
Tel: (437) 781-0611 **Email:** frontdesk@activemedicinetoronto.com
Fax: (437) 781-0586

PATIENT INFORMATION:

FHO, FHG or FHN Rostered Y☐ N☐

Name:	**DOB:**
Health Card #:	**Version Code:**
Address:	**City:**
Tel:	**Email:**

REASON FOR REFERRAL: (enter brief description)

SERVICE(S) REQUESTED:

Orthopaedic Surgery Consultation

☐ 1st available ☐ Dr. John Theodoropoulos ☐ Dr. Justin Chang
☐ Dr. Isaac Ryan Perlus ☐ Dr. Oren Zarnett ☐ Dr. James Campbell

Sports Medicine Consultation

☐ 1st available ☐ Dr. Nathaniel Ibey ☐ Dr. Jim Niu
☐ Dr. Rosamond Lougheed-Simpson ☐ Dr. Shane Mooney

MSK Injections

☐ Corticosteroid ☐ Hyaluronic Acid ☐ PRP/Biologics

Allied Health

☐ Physiotherapy ☐ Athletic Therapy ☐ Chiropractic Care/Soft Tissue

Diagnostic

☐ Biodex ☐ DXA Body Composition ☐ Gait Analysis

MSK Bracing

☐ Custom Knee Brace ☐ Pre-Fabricated Brace ☐ Compression Sleeves/Stockings

REFERRING PHYSICIAN INFORMATION:

Name:	**MOH Billing #:**
Tel:	**Fax:**
Address:	**Speciality:**

REFERRAL DOCUMENTATION INCLUDED:

*X-Ray with Report **REQUIRED** for **Orthopaedic Surgery Consultation** (completed within past 12 Months)*
*MRI with Report **REQUIRED** for **consultation with Dr. Theodoropoulos** (completed within past 12 Months)*
*X-Ray with Report **PREFERRED** for Sports Medicine Consultation*

☐ Referral Letter ☐ Recent Consult Note (re: event/patient history)
☐ Xray ☐ MRI ☐ U/S ☐ CT Scan

_____

REFERRING PHYSICIAN SIGNATURE