



ACTIVE MEDICINE TORONTO

Referral Request

Referral Date: _____

135 Yorkville Avenue, 2nd Floor, Toronto, Ontario, M5R 0C7
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

- | | | |
|--|--|---|
| ☐ 1 st available | ☐ Dr. John Theodoropoulos | ☐ Dr. Justin Chang |
| ☐ Dr. Isaac Ryan Perlus | ☐ Dr. Oren Zarnett | |

Sports Medicine Consultation

- | | | |
|---|---|--|
| ☐ 1 st available | ☐ Dr. Nathaniel Ibey | ☐ Dr. Jim Niu |
| ☐ Dr. Rosamond Loughheed-Simpson | ☐ Dr. Shane Mooney | ☐ Dr. Max Stone |

MSK Injections

- | | | |
|---|--|--|
| ☐ Corticosteroid | ☐ Hyaluronic Acid | ☐ PRP/Biologics |
| ☐ Arthrosamid® | | |

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:	Specialty:

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