

Phone: 778-738-4188

Fax: 778-699-4550



Physician Referral Form – Sports Medicine & Physiatry
URGENT REFERRALS: Referring physician please contact the clinic directly

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|---|---|
| Patient Information: Name: PHN: DOB: Gender: Address: Home Phone: Alternate Phone: Email: Secondary Contact: WCB Claim # (if applicable) | Referring Physician: Name: MSP: Address: Phone: Fax: Walk-in Clinic Name: (if applicable) Family Doctor: (if different than above) Date of Referral: |
| <input type="checkbox"/> Dr. Tin Jasinovic, Sports Medicine Physician <input type="checkbox"/> Dr. Jacob Boomgaardt, Physiatrist | |
| Duration of Symptoms: <input type="checkbox"/> < 6 weeks <input type="checkbox"/> > 6 weeks | Severity of Symptoms: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe |
| Location: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Foot/ankle <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Wrist <input type="checkbox"/> Other | |
| Reason For Referral: Include diagnosis & treatment to date, including imaging. For spasticity management please specify diagnosis and prior medications or procedural interventions trialed. <input type="checkbox"/> Letter Attached | |
| Medical & Surgical History: <input type="checkbox"/> History attached | |
| Medications: <input type="checkbox"/> List attached | Allergies: <input type="checkbox"/> List attached |

Receipt of referral will be confirmed via fax to the referring physician's office upon review and an approximate wait for the appointment will be indicated. Patients will be contacted by our office to schedule an appointment and the referring physician will be advised of the appointment date once scheduled, via fax.