Phone: 778-738-4188
Fax: 778-699-4550

Physician Referral Form – Sports Medicine

URGENT REFERRALS: Referring physician please contact the clinic directly

Patient Information:	**Referring Physician:**
Name: PHN: DOB: Gender: Address:	Name: MSP: Address: Phone: Fax:
Home Phone: Alternate Phone: Email: Secondary Contact:	Walk-in Clinic Name: (if applicable) **Family Doctor:** (if different than above)
WCB Claim # (if applicable)	**Date of Referral:**

☐ Dr. Tin Jasinovic, Sports Medicine Physician

Duration of Symptoms:	**Severity of Symptoms:**
☐ < 6 weeks ☐ > 6 weeks	☐ Mild ☐ Moderate ☐ Severe

Location: ☐ Hip ☐ Knee ☐ Foot/ankle ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Other

Reason For Referral: Include diagnosis & treatment to date, including imaging. For spasticity management please specify diagnosis and prior medications or procedural interventions trialed.

☐ Letter Attached

Medical & Surgical History: ☐ History attached

Medications: ☐ List attached	**Allergies:** ☐ 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.