

Patient referral form

Date of referral: _____

REFERRAL FOR ☐ OHIP funded ☐ PRIVATE

Patient information (please print)

Patient name:		Health card #:	
Date of birth (DD/MM/YYYY):		Telephone:	
Address:		City / Postal code:	

Clinical referral details

Reason for referral:
Diagnostic results, medical history, & precautions:

OHIP funding eligibility requirements

Treatment which is designed to maintain an existing level of function is not covered by this program. To qualify for public funding, patients must be assessed by a qualified physiotherapist as experiencing **acute episodes or worsening of symptoms** that lead to decreased function or mobility.

Patients must meet **at least one** of the following criteria (please check all that apply):

- | | |
|--|--|
| ☐ Age 19 or younger | Referral not mandatory. Precautions or protocols recommended. |
| ☐ Age 65 or older | Referral not mandatory. Precautions or protocols recommended. |
| ☐ Recently discharged from hospital | Referral and protocol recommended; services must relate directly to reason for admission |
| ☐ Eligible under ODSP or OW | Referral not mandatory. Precautions or protocols recommended. |

Healthcare practitioner referral & authorization

Healthcare practitioner name:		OHIP billing #:	
Practitioner signature:		Date of referral:	
Telephone:		Fax:	

*Please Note: The Referral should have a valid date.
 Please fax or email this completed form to our Elgin Clinic. Thank you for your referral!*