The Ability Clinic
BONE • MUSCLE • NERVE

REFERRAL FORM

Patient Information
Please include full cumulative patient profile

Name: _____ Date of Birth: _____

OHIP: _____ Phone : _____

Referring Provider

Name: _____ Date of Referral: _____

Address: _____ Fax: _____

Specialty: _____ Billing: _____

Medical

Physician:
- ☐ ***First Available***
- ☐ Specific Request: _____

Specialty:
- ☐ ***As Appropriate***
- ☐ Rheumatology
- ☐ Neurology
- ☐ Psychiatry
- ☐ Sports Medicine *(non-FHO friendly)*
- ☐ Physical Medicine and Rehabilitation
- ☐ Lifestyle/Preventative Medicine

Service:
- ☐ ***As Appropriate***
- ☐ Electrodiagnostic Testing *(NCS/EMG)*
- ☐ Ultrasound-Guided Injection *(cortisone, HA, PRP, nSTRIDE, Arthrosamid)*
- ☐ Botulinum Toxin Injection *(migraine, spasticity)*
- ☐ Body Composition Testing

Recovery & Wellness

Physiotherapy: ☐ Orthopedic ☐ Pelvic ☐ Vestibular ☐ Cancer

Massage: ☐ Relaxation ☐ Active Release ☐ Cancer

Other: ☐ Orthotics ☐ Custom Bracing ☐ DEXA ☐ Shockwave Treatment

Additional Information:

Investigations Attached: ☐ Imaging ☐ Labs ☐ EMG ☐ EEG ☐ Bone scan ☐ Other

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