

Airport Way Medical Clinic Referral Form
Telehealth Physiotherapy

Patient Stamp

Patient Name: _____

Phone: _____

Email: _____

DOB: _____

Assessment and treatment for:

- | | |
|--|--|
| <input type="checkbox"/> Acute/Chronic MSK Injury (incl. pre/post-op) | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Neuro Rehab | <input type="checkbox"/> Cardiorespiratory Rehab |
| <input type="checkbox"/> Concussion Rehab | <input type="checkbox"/> Pelvic Health |
| <input type="checkbox"/> Cancer Rehab | <input type="checkbox"/> Healthy Aging (OA) |
| <input type="checkbox"/> Exercise Consulting (injury/illness prevention) | <input type="checkbox"/> Pediatrics |

Diagnosis: _____

Complications/Comments: _____

Referring Professional: _____

Date: _____

Please fax referral and supporting chart notes to 778-508-7042

If patient is comfortable, they can proceed to book online at www.inreachphysio.ca
Otherwise, InReach Online Physio will contact patient by telephone once referral is received