Haliburton Highlands
Health Services

PHYSIOTHERAPY – OUTPATIENT REFERRAL

Box 115, Haliburton, ON, K0M 1S0   Telephone: 457-1392 (2226)   Intake Fax: (705) 457-2398

NOTE: To ensure appropriate prioritization, thorough completion of the referral is essential. Incomplete referrals may delay admission to therapy.

We no longer accept referrals for chronic conditions Clients with a chronic condition can be referred to attend one of our education classes if appropriate. Please use the Outpatient Education Class Referral form.

PATIENT: ____________________________ ______________________________ Date of Birth: ____/____/____
Last First dd/mm/yy

ADDRESS: ____

TELEPHONE: (________) ______-________ (h) (________) ______-________ (w)

WSIB: ☐ MVA: ☐

REFERRING DIAGNOSIS: ____

DATE OF ONSET/INJURY: ____/____/____ DATE OF SURGERY/PROCEDURE: ____/____/____
dd/mm/yy dd/mm/yy

Relevant Investigations	Completed	Pending	Findings
X-rays	☐	☐	
US	☐	☐	
MRI	☐	☐	
CT	☐	☐	
Other (eg. EMG)	☐	☐	

RELEVANT CLINICAL FINDINGS:

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RELEVANT MEDICAL HISTORY: (eg. Diabetes, Heart Disease, CA)

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PLEASE INDICATE ACUITY OF CONDITION: (based on OBJECTIVE findings, eg. diminished reflex, +SLR, significant loss of range, significant swelling.)

ACUTE ☐ (eg. post-surgery, post fracture immobilization, acute respiratory, recent CVA, acute sprain/strain.)

SUB-ACUTE ☐ (eg. rotator cuff disease, recent flare of chronic condition, DDD exacerbation, frozen shoulder.)
PLEASE NOTE: Due to the high volume of referrals, clients referred for treatment of a sub-acute condition will be seen only as time permits. Wait times may be lengthy. We recommend you inform your client of other physiotherapy services in your community.

FUNCTIONAL LIMITATIONS DUE TO CONDITION: Difficulty sleeping ☐ Unable to work ☐ Difficulty performing basic ADL's ☐

_________________________ _________________ ___________________
Physician's Signature Date Telephone

Revised Dec/07