Get Well Rehab
649 Sheppard Ave West
Toronto, ON, M3H 2S4
TEL: (416) 508-5691 | FAX: (647) 478-7604

getwell rehab.ca

REFERRAL FORM:

PATIENT INFO:

Name: ______________________________ *
Date of Birth: ____________________ (dd-mm-yyyy)
Gender: __________
OHIP #: __________________ * Version: _______ *
Address: _________________________
____
City: ______________ Postal Code: ___________
Phone: ____________________ *
Cell: ____________________
Email: ____________________
(personal, non-work)

(* Required fields)

Reason for Referral / Diagnoses:

Past Medical and Psychiatric Health:

Current Medications:

Rehab Clinic:
[ ] MVC Rehabilitation
[ ] WSIB Rehabilitation
[ ] Chiropractic
[ ] Physiotherapy
[ ] Vestibular Physiotherapy
[ ] Kinesiology
[ ] Acupuncture
[ ] Massage Therapy

Foot Clinic:
[ ] Chiropody / Foot Clinic
[ ] Custom Orthotic Insoles
[ ] Compression Stockings

Nutrition & Weight Management:
[ ] Nutrition / Dietitian

Mental Health:
[ ] Psychotherapy

Genetic Testing & Free Consults
[ ] Comprehensive Health Check Test
[ ] Drug Compatibility Test
[ ] Cannabis Sensitivity Test

Extended Health Insurance Navigation
[ ] Free consultation with an Extended Health Insurance Navigator

Referred by:	Physician/Clinic Stamp:
Name: ____________________	
Signature: ____________________	
Date (dd-mm-yyy): ____________________	

***** Please send a copy of recent relevant blood work, investigations, imaging, and consults *****

[v.20.03.11]