

For physiotherapists coordinating assessment, chiropractic care, rehabilitation, and return-to-activity planning.

PATIENT INFORMATION

PATIENT FULL NAME

DATE OF BIRTH (YYYY-MM-DD)

PHONE

EMAIL

MAILING ADDRESS

REFERRER INFORMATION

REFERRER NAME

PROFESSIONAL DESIGNATION

PRACTICE / ORGANIZATION

PHONE

PROFESSIONAL EMAIL

HOW DID YOU HEAR ABOUT RDSS?

AREA OF REFERRAL INTEREST

- | | |
|--|--|
| ☐ Chiropractic assessment | ☐ Coordinated or complementary care |
| ☐ Hands-on care consideration | ☐ Post-injury rehabilitation |
| ☐ Return to activity or sport | ☐ Running assessment |
| ☐ Strength and conditioning | ☐ Concussion care pathway |
| ☐ Clinical yoga active care | ☐ GLA:D Hip programming |
| ☐ GLA:D Knee programming | ☐ Other / unsure where to start |

REASON FOR REFERRAL

WHAT PROMPTED THIS REFERRAL?

PATIENT GOALS AND ACTIVITIES THAT MATTER TO THEM

RELEVANT HISTORY, FINDINGS, PRECAUTIONS, OR COORDINATION NOTES

DOCUMENTS TRAVELLING WITH THE PATIENT

- | | |
|---|--|
| ☐ Relevant report or imaging summary | ☐ Medication list |
| ☐ Current care or exercise plan | ☐ No attachments |
| ☐ Other | |

PATIENT CONSENT

I authorize the referring professional named on this form to share the information recorded here and any listed attachments with Red Deer Sport + Spine for the purpose of coordinating this referral. I understand that I may withdraw this authorization before the information is provided.

PATIENT / LEGAL REPRESENTATIVE PRINTED NAME

DATE (YYYY-MM-DD)

PATIENT / LEGAL REPRESENTATIVE SIGNATURE (SIGN AFTER PRINTING)

REFERRER SIGNATURE

RETURN: GIVE THE PRINTED FORM TO THE PATIENT OR SECURELY FAX IT TO (587) 951-1058.