

For registered massage therapists coordinating assessment, rehabilitation, movement, and return-to-activity planning.

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**PATIENT INFORMATION**

PATIENT FULL NAME

DATE OF BIRTH (YYYY-MM-DD)

PHONE

EMAIL

MAILING ADDRESS

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**REFERRER INFORMATION**

REFERRER NAME

PROFESSIONAL DESIGNATION

PRACTICE / ORGANIZATION

PHONE

PROFESSIONAL EMAIL

HOW DID YOU HEAR ABOUT RDSS?

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**AREA OF REFERRAL INTEREST**

- |                                                           |                                                            |
|-----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Chiropractic assessment          | <input type="checkbox"/> Coordinated or complementary care |
| <input type="checkbox"/> New or recurring pain concern    | <input type="checkbox"/> Post-injury rehabilitation        |
| <input type="checkbox"/> Movement and mobility assessment | <input type="checkbox"/> Return to activity or sport       |
| <input type="checkbox"/> Strength and conditioning        | <input type="checkbox"/> Running assessment                |
| <input type="checkbox"/> Clinical yoga active care        | <input type="checkbox"/> GLA:D Hip programming             |
| <input type="checkbox"/> GLA:D Knee programming           | <input type="checkbox"/> Other / unsure where to start     |

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**REASON FOR REFERRAL**

WHAT PROMPTED THIS REFERRAL?

PATIENT GOALS AND ACTIVITIES THAT MATTER TO THEM

RELEVANT HISTORY, FINDINGS, PRECAUTIONS, OR COORDINATION NOTES

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**DOCUMENTS TRAVELLING WITH THE PATIENT**

- |                                                             |                                          |
|-------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Relevant report or imaging summary | <input type="checkbox"/> Medication list |
| <input type="checkbox"/> Current care or exercise plan      | <input type="checkbox"/> No attachments  |
| <input type="checkbox"/> Other                              |                                          |

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**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

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