STUDIO **ATHLETICA** & PUSH **POUNDS**

366 Bay Street, 10th Floor, Toronto, ON, M5H 4B2
Tel: 416.722.3393 | **Fax:** 416.583.2232 | **Toll Free:** 1.877.432.0982

Consultation Request

Referring to Specialty: _____

☐ Orthopaedic surgeon ☐ Interventional Musculoskeletal Radiology ☐ Pain Medicine
☐ Sports medicine ☐ Physical medical and rehabilitation

Patient Information	Physician Information
Patient Name:	**Physician Name:**
DOB:	**Address:**
Health Card:	**Phone:**
Address:	**Fax:**
Home Phone:	**Provider Number:**
Work Phone:	**Specialty:**
Cell Phone:	**Family Physician:** (if not referring MD)

Reason for Referral
(Include diagnosis and treatment to date)

Medical and Surgical History

Medications	Allergies

Radiology Report Attached
(If available)

☐ **MRI** ☐ **CT SCAN** ☐ **X-ray** ☐ **Ultrasound** ☐ **Other** _____

Referring Physician Signature **Date**

_____ _____