ERINDALE ORTHOPAEDIC SPORTS INJURIES &
REHABILITATION CENTRE

1645 Dundas Street West
Mississauga, ON L5C 1E3

Tel: 905-306-1200
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Physiotherapy Referral Form

Date: _____

(Attach patient's sticker here)
Name:
DOB:
Tel:

Date of Injury / Surgery: _____

Diagnosis: _____

☐**MVA** ☐**Extended Health / Private**

Recommended Treatment:

☐**ROM**	☐**Stretching**	☐**Strengthening**	☐**Functional**
☐ **SHOCKWAVE**	☐**Manual Therapy**	☐**Electrotherapy**	☐ **Acupuncture**
☐ **Home Exs/Education**	☐**Post-op Protocol**	☐**Gait / Balance**	☐**Core Muscle**

☐**Registered Massage Therapy**

Custom Made Braces: ☐**ACL** ☐**Offloader medial** ☐**Offloader lateral**

Bauerfeind Brace: ☐**GenuTrain** ☐**A3** ☐**P3** ☐**S** ☐_____

☐**Bone Stimulator** ☐**Dynasplint/Jas**

Viscosupplement Therapy: ☐**Cortisone** ☐**Neovisc** ☐**PRP/ACP**

Orthotics: ☐**Foot** ☐**Other:** _____

WB Status: ☐**NWB** ☐**Touch WB** ☐**PWB:** ____ **%** ☐**WBAT** ☐**FWB**

Precautions: _____

Referring Physician: _____