For APPOINTMENTS, CALL (519) 631-2020
Ext 2322
Between 8:00AM – 4:00PM Mon-Fri only
FAX (519) 631-8842

APPOINTMENT DATE AND TIME

PATIENT INFORMATION

Last Name_________________________ First Name _________________

Address___________________________________ DOB_____________
(YY/MM/DD)

(H) Phone # ____________________(C) Phone#______________________

Health Card #_________________________VC_____

Gender Height(cm) Weight (kg)__________

WSIB ☐Yes
Date of injury____________________

Claim #___________________________

Mobility Issues/Special Needs

Yes☐_____________________________

Important: Please bring your health card. No children allowed in the exam room. Please arrange child care.

Therapeutic Joint/Bursa Injection/Arthrogram

Shoulder
R L
☐ ☐ **Glenohumeral Joint** ☐ **Repeat___mnths**
☐ ☐ **Acromioclavicular Joint/ Subacromial Bursa** ☐ **Repeat___mnths**

Wrist
R L
☐ ☐ **Radiocarpal Joint** ☐ **Repeat___mnths**

Thumb (1st Carpometacarpal)
R L
☐ ☐ ☐ **Repeat___mnths**

Pelvis
R L
☐ ☐ **Sacroiliac Joint** ☐ **Repeat___mnths**
☐ ☐ **Femoracetabular Joint** ☐ **Repeat___mnths**
☐ ☐ **Gr. Trochanteric Bursa** ☐ **Repeat___mnths**
☐ ☐ **Iliolumbar Ligament** ☐ **Repeat___mnths**
☐ ☐ **Piriformis** ☐ **Repeat___mnths**

Knee
R L
☐ ☐ **Knee** ☐ **Repeat___mnths**

Ankle
R L
☐ ☐ **Subtalar Joint** ☐ **Repeat___mnths**
☐ ☐ **Tibiotalar Joint** ☐ **Repeat___mnths**

Foot
R L
☐ ☐ **Tarsometatarsal Joint** ☐ **Repeat___mnths**
Indicate which tarsal bone:________
☐ ☐ **Plantar Fascia** ☐ **Repeat___mnths**

TMJ
R L ☐ **Repeat___mnths**
☐ ☐

For other sites/Procedures, please specify

____

Facet Injection

R L
☐ ☐ **Cervical** ☐ **Levels_______** ☐ **Repeat___mnths**
☐ ☐ **Thoracic** ☐ **Levels______** ☐ **Repeat___mnths**
☐ ☐ **Lumbar** ☐ **levels_______** ☐ **Repeat___mnths**

Epidural

R L
☐ ☐ **Cervical** ☐ **Repeat___mnths**
☐ ☐ **Thoracic** ☐ **Repeat___mnths**
☐ ☐ **Lumbar** ☐ **Repeat___mnths**

Clincal Indication

REFERING PHYSICIAN

Referring Physician______________________________
(Print Name)

Signature_______________________________________

Billing Provider #

CPSO#_______________

Tel# _________________**FAX #**_____________________

Date:______________________