Dr. Paul Schwann Centre

MUSCULOSKELETAL CONDITIONING REFERRAL

*****This is NOT a Cardiac Rehabilitation, Chronic Disease or Risk Reduction Program Referral*****

Client Name: _____, _____ **DOB:** ____/____/_____
(Please Print) Last name First name mm dd yyyy

Phone (h): _____ **(w):**_____ **Family Physician:** _____

Referral Type: □ Private Payer □ SGI □ WCB □ Other (please list) _____

Has WCB client been off work > 4 weeks? □ yes □ no **Claim #:** _____

Date of Injury: _____/_____/_____ **Adjuster Name:** _____
mm dd yyyy

Musculoskeletal Diagnosis:

_____

_____

_____

Current Medications:

_____

_____

Service(s) Requested: □ Musculoskeletal Rehab □ Health/Fitness Assessment □ General Fitness Training
□ Cybex □ Lung Function Test □ Other

Special Instructions:

_____

_____

_____

Contraindications & Relevant Medical History:

_____

_____

_____

Anticipated Treatment Length (if WCB or SGI): _____

Referred by: _____ **Signature:**_____
(please print)

Occupation: _____ **Phone:** _____ **Date:** ____/____/_____
mm dd yyyy

*****Please complete referral form and return by fax to (306) 585-5363*****