AVENUE
CHIRO & REHAB

848 Fennell Ave East, Suite 103
Hamilton, ON, L8V 1W1
admin@avechirorehab.ca
P: 647-490-0740
F: 855-940-3657

Patient Referral Form

Referring Healthcare Provider Information

- Referring Provider Name: _____
- Referring Provider Specialty: _____
- Referring Provider Phone: _____
- Referring Provider Fax: _____
- Referring Provider Email: _____

Patient Information

- Patient Full Name: _____
- Date of Birth: _____ Age: ____
- Gender: [ ] Male [ ] Female [ ] Other
- Contact Phone Number: _____
- Address: _____
- City: _____ Province: _____ Postal Code: _____
- Primary Care Physician (if different): _____

Reason for Referral

- Diagnosis/Condition: _____
- Current Symptoms: _____
- Relevant Medical History: _____
- Medications: _____
- Allergies: _____

Requested Specialist/Provider Information

- Specialist/Provider Name: _____
- Specialty: _____
- Provider Phone: _____
- Provider Fax: _____
- Provider Email: _____

PLEASE FAX COMPLETED FORM TO 855-940-3657

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Authorization and Consent: I hereby authorize the release of medical information, including but not limited to medical records and diagnostic test results, to the referred specialist/provider for the purpose of evaluation and treatment.
I understand that this information will be used solely for medical care and treatment purposes.

Patient Name: _____

Patient's Signature:

_____ Date: _____

Referring Healthcare Provider Signature:

_____ Date: _____

Please retain a copy of this referral form for your records.
If possible, feel free to fax any necessary patient records, to the referred specialist/provider to ***855-940-3657.***
For questions or further information, please contact our office at admin@avechirorehab.ca or 647-490-0740.

Thank you for your kind referral!

Avenue Chiro & Rehab Team

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