HIGHMARK HEALTH

Complex Injury Rehab
The Brain, Spine & Mental Health Clinic

PATIENT REFERRAL FORM

PATIENT INFORMATION

Patient First & Last Name:	
Address:	
DOB (dd/mm/yy):	Phone:
Health Card No:	Version Code:

AREAS OF CONCERN/REASON FOR REFERRAL

- ☐ Concussion Management
- ☐ Orthopaedic Injury
- ☐ Occupational Therapy
- ☐ Chiropractic Care
- ☐ Massage Therapy
- ☐ Splinting/Bracing
- ☐ Cognitive Therapy
- ☐ Stroke Rehab
- ☐ Hand Therapy
- ☐ Social Work
- ☐ Therapeutic Yoga
- ☐ Compression Hosiery/Orthotics

Additional Information:

REFERRING PHYSICIAN INFORMATION

Name:	Billing No:
Address:	Fax:
Signature:	Date:

Please fax completed form with medical chart and/or any relevant investigations to 905-839-9444.
Referring physician please provide fax number for consult notes.
Complex Injury Rehab will contact the patient to schedule an appointment.
Thank you for your referral.

Complex Injury Rehabilitation
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