THE INSTITUTE OF

HUMAN MECHANICS

Consultation Referral Form

Physician Consultation: ☐ Avenue Road Clinic ☐ Browns Line Clinic	**Patient Name** *(Last, First)*: DOB *(dd/mm/yy)*:
Name of Referring Physician:	Health Card Number:
Address: Tel:	Address:
Fax: OHIP Billing #:	Telephone Number(s):
Reason for Referral *(please print)*: Mechanism of Injury *(please specify)*: Date of Onset/Injury:	
Investigation Results *(Patient to bring CDs of X-rays/MRI if already completed)*:	
Signature:	Date:

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