GROUP23
SPORTS MEDICINE

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Group23.ca

Patient Referral

Please have all the information filled out to have the referral triaged efficiently.

Patient Demographics

First & Last Name:

Healthcare Number:

☐ AB Healthcare ☐ Other Province:

Date of Birth:

Primary Phone:

Email:

Address:

Referring Practitioner

First & Last Name:

Practitioner ID#:

Designation:

Clinic/Facility Name:

Phone:

Fax:

Address:

Referral To

☐ First Available
☐ Specific practitioner: _____

Referral For

☐ Sports Medicine Physician Consultation
☐ Physiatry Consultation
☐ Physiotherapy
☐ Sports Massage Therapy
☐ Custom Bracing/Orthotics
☐ Weight & Lifestyle Management

***Please Note:** Group23 **does NOT accept** medical legal cases, MVA cases, WCB cases, or surgical consults.

Injury Information

Initial date of injury (symptom onset):

_____

Mechanism of injury:

_____

☐ Right ☐ Left
☐ Knee ☐ Elbow
☐ Hip ☐ Wrist
☐ Ankle ☐ Other: _____
☐ Shoulder

Diagnosis & history: _____

_____

_____

_____

Treatment to date: _____

Other healthcare professionals involved in care: _____

Pending consultations: _____

Previous Imaging: ☐ X-Ray ☐ MRI ☐ Ultrasound ☐ Bone Scan ☐ CT Scan

*Please attach pertinent imaging to the referral

If you do not receive a referral receipt notice within 14 days of sending the referral, please re-fax the referral. We will contact the patient once the referral is triaged via the phone number you provided.

Signature: _____

Thank you for choosing Group23 Sports Medicine