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
☐ Physiotherapy
☐ Custom Bracing/Orthotics
☐ Sports Massage Therapy
☐ Weight & Lifestyle Management

***Please Note:** Group23 **does NOT accept** medical legal cases, MVA cases, WCB cases, surgical consults, or back/neck injuries that are non-sport related and/or chronic (>6 months).

## 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