

PHYSIATRY REFERRAL FORM

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Dr. Rehana Murani
 BSc, MD, FRCPC (Physical Medicine
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 Dip. Sports Med

Referrals will be triaged and scheduled with the first available provider

Name: _____ Date of Birth _____ ULI: _____
 Address: _____
 Home Phone: _____ Work Phone: _____ Cell Phone: _____

REFERRAL INFORMATION

Priority

Urgent Routine

*For urgent requests please indicate why, or
 call the clinic to discuss with one of our
 physicians*

Referring Physician

NAME: _____

PRAC ID: _____

Phone: _____

Fax: _____

Physician to Receive Copies

WCB Number _____

CLINICAL QUESTION

- Spasticity/ Tone Assessment Dystonia Neuromuscular Rehabilitation
 Bracing/ Orthotics Acute MSK/ Adult Sport Injury Ultrasound Guided Injection
 Neuropathic Pain Management Other _____

Relevant History and Examination: (include any relevant investigations, imaging studies, consults and prior EMG studies)

Referring Physician Signature: _____ Date: _____

*Please fax completed referral to ANC
 at 587-747-5616*