PHYSICIAN REFERRAL FORM

Rory Shott – MD (CCFP), PhD
Cor Medical Centre
5504 Macleod Trail SW, Unit 170

REFERRING PHYSICIAN INFORMATION

Physician Name:

Clinic Name:

PRAC ID:

Phone:

Signature:

Fax:

PATIENT INFORMATION

Last Name:

First Name:

PHN:

Phone:

DOB:

REQUEST CONSULTATION FOR:

- ☐ Myofascial pain
- ☐ Chronic migraine
- ☐ Tension headaches
- ☐ Osteoarthritis
- ☐ Peripheral nerve entrapment
- ☐ Trigger finger
- ☐ Plantar fasciitis

PATIENT SUMMARY

☐ Referral letter enclosed

Please include any relevant details of the issue of concern, including PMHx, PSHx, imaging, current medications and allergies