1.2P

REFERRAL FORM

Please note that individuals with the following conditions can **NOT** be referred for treatment:

- *Bleeding disorders*
- *Pregnancy*
- *Anti-coagulated patients*
- *Immunocompromised patients*

REFERRING PHYSICIAN INFORMATION

Attention MOA: Please submit a No-Charge referral **03333** to MSP billing #**63566** (Dr R. Dhanoa) and fax this form to **604-637-5617**

Physician name:

MSP number:

Clinic name/address:

Telephone:

Fax:

PATIENT INFORMATION

Surname:

First name:

Date of birth (DD/MM/YYYY):

PHN:

Home phone #:

Cell phone #:

Address:

Gender

City/Province:

Postal code:

REFERRAL TO: Vancouver Clinic ☐ Delta/Surrey Clinic ☐

REASON FOR REFERRAL (Enclose history & investigations +/- referral letter)

Language barrier? NO YES (Please advise patient to bring interpreter if language barrier)

Clinical/infection precautions? NO YES :

Physician signature:

Date:

Vancouver location: Suite 912 - 750 W Broadway, Vancouver, BC V5Z 1H8
Delta location: Suite 202 - 8035 120th Street, Delta, BC V4C 6P9
Tel: 604-537-5635 Fax: 604-637-5617 Website: www.musclemd.ca