Catalyst for Health Medical Clinic

Electrodiagnostic Medicine/Physical Medicine and Rehabilitation

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Physiatry Assessment

Patient Information

Name: _____
DOB: _____
Gender: _____
PHN: _____
Address: _____
Phone: primary _____
alternate_____
Email: _____

Referring Physician

Name: _____
Address: _____
_____
Phone: _____
Fax: _____
Prac ID: _____

WCB Claim No. _____ **Case Worker Name:**_____
Date of Accident _____ **Phone:** _____

Consultation requested for:

❑ Spasticity ❑ Dystonia

❑ Musculoskeletal ❑ Sports injuries

❑ Botulinum injection for Migraine

Is this referral ***URGENT*** ❑ Yes ❑ No

CLINICAL INFORMATION: *(Please include relevant previous MRI's, X-rays, Blood Work, Medication List)****

Physician's Signature:

Date: