University Centre
550 University Ave, 2nd floor
Toronto, ON, M5G 2A2
Tel: 416-597-3422 ext: 4514
Fax: 416-597-7174

MUSCULOSKELETAL OUTPATIENT THERAPY CENTRE REFERRAL

Reason for referral:

☐ Musculoskeletal Conditions: Fractures, bone and tendon surgical repairs, MSK spinal surgeries (injury/surgery within 3 months)

☐ Total Joint Replacement: Acute Hip and Knee replacements – revisions and bilaterals

☐ Cancer Outpatient Rehabilitation (COR) Program: Musculoskeletal and select neurologic conditions directly related to the oncology diagnosis or treatment

Patient Information	
Name:	☐ M ☐ F
Address:	
Tel (home):	
Tel (cell):	
Date of Birth (mm/dd/yyyy):	
Health Card#:	VC:
Interpreter? ☐ No ☐ Yes - Language:	

Referring Physician	
Name:	
Address:	
Tel:	Fax:

Patient's Emergency Contact Information	
Name:	Relationship:
Tel (home):	Tel (cell):

Medical Information (to be filled by physician)	
Diagnosis / Surgery:	Date of Onset / Surgery:
Functional Goals and/or Limitations:	
Past Medical History:	
Weight Bearing Status and Precautions/Contra-Indications:	
Please Include with this form: ☐ Medication List ☐ Results of Investigations (e.g. CT, MRI, X-Ray, Ultrasound, etc…) ☐ Consultation notes relevant to diagnosis (MD, OT, PT, RMT, etc…)	

Patients in our program are treated by an interdisciplinary team which may include a physician. By signing this referral, I agree to have the referred patient assessed by a Toronto Rehab physician as required.

*Please note: For oncology patients ONLY, this assessment will be conducted by a physiatrist (Dr. Eugene Chang or Dr. David Langelier) and may occur at Toronto Rehab or Princess Margaret Cancer Rehabilitation and Survivorship Program. For MSK patients, this assessment may occur with one of our MSK physiatrists.

Physician Name _____ Billing Number _____ Signature _____ Date _____