

Consultation Request

PATIENT INFORMATION: Name Date of Birth		REFERRING PROFESSIONAL: Name Fax No.							
					Phone 1 Pho	one 2	Phone No.		
					Health Card No.		Request Date		
Address		Case Type	WCB Community Services	☐ MVA ☐ N/A					
PREFERRED LOCATION: DOWNTOWN HALIFAX Park Lane Mall 1554 Dresder Row, Suite 3070 Halifax, NS B3J 2K2 PHONE: 902-442-5199 Services indicated below with an aster are only available at this location.	CLAYTON PA Clayton Park Shoppin 278 Lacewood Drive Halifax, NS B3M 3N8 PHONE: 902-404-84	g Centre	Millstor 250 Ba Dartmo PHON I Servic	TTMOUTH ne Square at Russell Lake aker Drive, Suite 124 buth, NS B2W 6L4 E: 902-404-8352 es indicated below with an asterisk * ly available at this location.					
FREDERICTON 1113 Regent Street, Suite 300 Fredericton, NB E3B 3Z2 PHONE: 506-474-0340									
PATIENT DIAGNOSIS:									
REASON FOR REFERRAL:									
Osteoarthritis Ligament Patellofemoral Compress Upper Extremity Bracing Shoulder Wrist Elbo Back Bracing Thoracic Lumbar SI Maternity Bootwalkers/Foot & Ankle Achilles Bunion Diabetic Night Spli	WAVE W Cold Therapy HA Therapy Image Guided Compression S Both Legs Compression 20-30 mm	Immobilizers sion Therapy Therapy Stockings Single Leg: (L)	Ma Bone Gro Orthotist Physiothe Massage Chiroprac Shockwa (R) Dry Need	erapy* Therapy* ctic Services*					
Medications		Allergies							
PHYSICIAN SIGNATURE:									