Referral Form

LifeSpring Physiotherapy

Tel: (905) 713–2427
Fax: (905) 713 2910
info@lifespringclinics.ca
www.lifespringclinics.ca

2 Orchard Heights
Boulevard Suite #36
Aurora, ON L4G 3W3

Patient Information

Date of Referral:

Name: _____

Phone: _____

Diagnosis / Contraindications / Comments:

_____

_____

_____

☐ As per discretion of the treating practitioner

Treatment Required:

☐ Physiotherapy	☐ TMJ Rehabilitation	☐ Neuro Rehabilitation
☐ Massage Therapy	☐ Sports Rehabilitation	☐ Parkinson's, MS, Stroke Rehab
☐ Exercise Therapy	☐ Customized Orthotics	☐ Pelvic Health Physiotherapy
☐ Acupuncture	☐ Assistive Devices & Braces	☐ Concussion Rehabilitation
☐ Manual Therapy	☐ Posture Clinic	☐ Shockwave Therapy
☐ Traction	☐ Vestibular Rehabilitation	☐ Chiropractic Treatments
☐ In-Home Physiotherapy	☐ Mckenzie Method®	☐ Compression Hose

Physician Information:

Referring Physician: _____ Phone: _____

Signature: _____

Thank You