Self-Referral Physiotherapy

Please be advised all Information is private and confidential. We recommend this form be hand delivered to the clinic as it contains personal health information.

Welcome, and thank you for choosing Work-Fit Total Therapy Centre.

Please ensure you meet the criteria for the Ontario Community Physiotherapy Clinic service using the link below:

https://www.ontario.ca/page/physiotherapy-clinics-government-funded#section-1

The team will review each form to determine if you meet criteria. If any area is blank, we will not be able to move forward with processing your request. **Wait times vary per location**.

DATE: _____

LOCATION PREFERRED: ☐ Oakville ☐ Milton ☐ Georgetown

Client Information

Name: _____ Gender ☐ Male ☐ Female

Address: _____

City: _____ Province: _____ Postal Code:_____

Phone #: Home: _____Work: _____ Cell: _____

Email: _____Age: _____ Date of Birth: Day_____Month_____Year_____

Occupation: _____ Health Card #: _____ Version Code: _____

Emergency Contact Name: _____Phone #: _____Relationship: _____

Recipient of Ontario Works or Ontario Disability Support Program ☐ Yes ☐ No Member ID Number: _____

Medical Information

Family Physician: _____ Phone #:_____City: _____

Do you have any of the following conditions:

□ Heart Condition	□ Metal Implants	□ Pregnant	□ Recent surgery
□ Pacemaker	□ Epilepsy	□ Cancer	□ Diabetes
□ Low Blood Pressure	□ High Blood pressure	□ Other_____	

Chief Complaint

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Reason for this appointment? (Chief Complaint) _____

Is this condition: □ New □ Chronic □ Flare Up

When did your condition begin? _____

Rate your pain on a scale from 0-10: _____ (0= No Pain, 10+= Maximal Pain)

Have you seen a health care professional for this condition? □ Yes □ No. Who?:_____

Have you seen a physiotherapist for this condition? □ Yes □ No. Who?:_____

Have you had any test done related to this injury (i.e. MRI, ultrasound, x-ray, bone scans) □ Yes □ No

If yes: Date: _____ Testing type: _____

Recent Hospitalization/Surgery ☐Yes ☐No Hospital Attended _____

Date of Surgery or Hospitalization _____

Reason for Hospitalization: _____

Any Further Information Relevant to this Injury _____

Consent

By signing below, you understand and consent to proceed with the screening process to ensure you are eligible for service with the Ontario Community Physiotherapy Clinic.

_____ _____

Signature of Client (Parent/Guardian if < 16 yrs of age) Date

_____

Printed Name of Client

FOR OFFICE USE ONLY

Ontario Community Physiotherapy Clinic Criteria Met ☐Yes ☐No
If no, Community Programs Provided Date: _____

Priority □ Urgent □ Non-Urgent

Comment _____

_____ _____

Signature of Physiotherapist Date of Review

_____

Printed Name