

Please check one: **First Available Physiatrist**
 Dr Ross A. Davidson MD, FRCPC, CSCN (DIP) 67539 **Dr Janine Reid, MD, FRCPC, CSCN 37587**
 Dr Philip Motyka MD, FRCPC, CSCN 35190 **Dr Sami Zaki MB, BCh, FRCPC(C) 67112**

Patient information (or attach clinic face sheet)		Referring Physician information (inc MSP #)	
Last Name, First Name		Referring Physician Address, Phone & Fax #	
PHN		MRP	
Date of Birth: M/D/Y	Sex: M F	CC:	
Mailing Address & Phone #			

Insurance Information

Referral related to a worksafe claim*?	yes <input type="checkbox"/> no <input type="checkbox"/>	Claim #	Date of injury
Referral related to a motor vehicle accident?	yes <input type="checkbox"/> no <input type="checkbox"/>	Claim #	Date of injury

Referral Information

General Physiatry consult: Nanaimo <input type="checkbox"/> Campbell River <input type="checkbox"/> Port Alberni <input type="checkbox"/> Tofino <input type="checkbox"/> Powell River <input type="checkbox"/> Snuneymuxw <input type="checkbox"/>	Spasticity <input type="checkbox"/> Musculoskeletal disorders <input type="checkbox"/> Chronic pain <input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Stroke rehabilitation <input type="checkbox"/> Amputee rehabilitation <input type="checkbox"/> Other <input type="checkbox"/> _____
	Electrodiagnostic Evaluation (Nanaimo ONLY) Radiculopathy <input type="checkbox"/> Polyneuropathy <input type="checkbox"/> Mononeuropathy <input type="checkbox"/> _____ Neuromuscular Junction disorder <input type="checkbox"/> Myopathy <input type="checkbox"/> Motor Neuron disorder <input type="checkbox"/> Plexopathy <input type="checkbox"/> Ulnar Neuropathy <input type="checkbox"/> **For CTS, recent Hb A1C #: _____ Date: _____ Carpal Tunnel Syndrome <input type="checkbox"/> and recent TSH #: _____ Date: _____ Has nocturnal bracing been trialed? Yes <input type="checkbox"/> No <input type="checkbox"/> *If not done yet, please have patient trial nocturnal bracing and update Hb A1C/TSH

Brief History: _____

Recent bloodwork attached Relevant imaging studies and/or specialist consults attached

What is the urgency of this referral? Routine Semi-Urgent **Urgent**

*Worksafe cases will **not** be expedited unless a request from WorkSafe is received*
 Campbell River/Comox/Powell River/Port Alberni clinic is for a **SELECT group of patients who are living with a disability **AND** have transportation difficulties or risks to health associated with transportation**



502-1515 Dufferin Crescent Nanaimo, BC V9S 5H6 Ph: 778-787-1707 F: 250-713-4422

****WE REQUIRE SUPPORTIVE INFORMATION TO BE ATTACHED TO REFERRAL****