BFHT Physiotherapy Referral Form

Burlington Family Health Team Physiotherapy (formerly B-CARS)

Date (MM/DD/YYYY): ____/____/_____ **Referring Practitioner:** _____

Referring provider telephone: (____) _____-_____ **Fax**: (____) _____-_____

Primary Care Provider (PCP): _____

Address: _____

Patient Name: _____

Date of Birth (MM/DD/YYYY): _____/_____/_____ **Phone:** (____) _____-_____

Address: _____

_____ **email:** _____

REFERRAL CRITERIA:

Please note: Patients are **not eligible if they are 19 or under, have an active MVA or WSIB claim, or have private Physiotherapy coverage.

Additionally, the patient **must** meet one of the criteria below *(Please check which criterion applies)*

- ◯ **Patient is over 19 and under 65 with any condition requiring Physiotherapy**
- ◯ **Patient is 65+ and has a stable chronic condition requiring Physiotherapy**
- ◯ **Patient is over 19 and being referred to one of our group programs:**
  - **Hip and Knee Osteoarthritis Exercise Program (GLA:D Canada)**
  - **Pulmonary Rehabilitation Program**
  - **Chronic Pain Program (Living Better with Pain)**

If patient is 65+ and does not meet any of the above criteria. Please fax this form to an OHIP clinic:
Advanced Physiotherapy (Fax: 905-315-7156) | **Brant Active Physiotherapy** (Fax: 905-681-6389*)*

Reason for Referral: Physiotherapy

Please Specify Body Part (if applicable): _____

Diagnosis: _____

**** Please provide relevant diagnostic imaging results ****

** Please fax completed referral to 1-(855) 764-8360 **

Burlington Family Health Team Physiotherapy | physiotherapy@burlingtonfht.com | www.burlingtonfht.com
1182 North Shore Blvd. East, Burlington, ON, L7S 1C5 | T: 289-861-5611 Ext. 5512 · F: 1-855-764-8360