Burlington
Family Health Team

BFHT Physiotherapy Referral

REFERRAL CRITERIA:

- Adults between the **ages of 19-64**
- All clients must be medically and functionally appropriate to exercise in a community setting, and cognitively appropriate for a group-based program

EXCLUSIONS:

- Currently receiving Physiotherapy treatment through extended health benefits, WSIB/MVA claims
- Eligible for OHIP-funded Physiotherapy (e.g. ages < 19 years or > 65 years, Ontario Disability Support Program/Ontario Works recipients, recently discharged from hospital and now qualify for OHIP-funded physiotherapy)

Date (MM/DD/YYYY): ____/____/________ **Referring Physician:** ______________________________

Physician Telephone: (____) _______-_____________ **Fax**: (____) _______-_______________

Family Physician: ____

Physician Telephone: (____) _______-_____________ **Fax**: (____) _______-_______________

Patient Name: ____

Date of Birth (MM/DD/YYYY): ____/____/_________ **Phone:** (____) ______-______________

Address: ____

____________________ **email:** ____

Reason for Referral: ◯ Chronic MSK condition ◯ Osteoarthritis ◯ Other

Diagnosis: ____

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**** Please ATTACH Relevant Diagnostic Imaging Results ****

Patient Goal: ◯ Improve function ◯ Decrease pain ◯ Improve Quality of Life

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