ALEXANDER RABINOVICH
ORTHOPAEDIC SURGEON
BSc MD FRCSC

# REFERRAL LETTER

| PATIENT | REFERRING PHYSICIAN |
|---|---|
| FIRST NAME | NAME |
| LAST NAME | BILLING # |
| HCN | PHONE |
| DOB (M/D/Y) | FAX |
| PHONE | ADDRESS |
| ADDRESS | |

**DATE:** _____

1) **REASON FOR CONSULTATION**

2) ATTACH MEDICAL HISTORY

**Note:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**REASON FOR CONSULTATION:** (select all that apply)

☐ **LEFT** ☐ **RIGHT**

**Foot / Ankle**
- ☐ Bunion ☐ Hammer Toe
- ☐ Corns ☐ Calluses
- ☐ Neuroma ☐ Fibroma
- ☐ Arthritis ☐ Deformity
- ☐ Instability ☐ Sprain
- ☐ Tendonitis ☐ Synovitis
- ☐ Diabetic ☐ Neuropathy
- ☐ Ganglion ☐ Tumor
- ☐ Heel Spur ☐ Fasciitis
- ☐ Flat foot ☐ High Arch
- ☐ Achilles Tendinopathy
- ☐ Bony Deformities

**Pelvis / Spine**
- ☐ Arthritis ☐ Deformity
- ☐ Neuropathy
- ☐ Back Pain

**Other**
- ☐ Chronic Pain Syndrome
- ☐ Fibromyalgia
- ☐ Rheumatoid Disorder
- ☐ Inflammatory Arthritis
- ☐ Infection / Ulcer
- ☐ Fractures

**Knee / Hip**
- ☐ Arthritis ☐ Deformity
- ☐ Instability ☐ Sprain
- ☐ Deformity ☐ Contracture
- ☐ Loose Body ☐ OCD
- ☐ Meniscus ☐ Labral Tear

**Shoulder / Elbow**
- ☐ Arthritis ☐ Deformity
- ☐ Instability ☐ Sprain
- ☐ Loose Body ☐ OCD
- ☐ Tendonitis ☐ Tears

**Wrist / Hand**
- ☐ Arthritis ☐ Deformity
- ☐ Instability ☐ Sprain
- ☐ Tendonitis ☐ Tears

**Other:**

_____

_____

_____

_____

c/o Performance Physiotherapy
50 Dundurn Street South, Unit 114
Hamilton, Ontario
L8P 4W3, Canada

PHONE: 289. 389. 8181
FAX: 289. 389. 8111
office@DrAlex.ca
www.DrAlex.ca