Newfoundland Balance & Dizziness Rehab Inc.
60 Elizabeth Ave, St. John's, NL A1A 1W4
Phone/Fax: 709-700-1474
Email: info@nlbalance.com Website: www.nlbalance.com

Sports Medicine Referral Form

Please fax completed form to NL Balance & Dizziness Centre at ***(709) 700-1474.***

Patient Information			
Name:			
Address:			
Phone:		Date of Birth:	
MCP #:		MCP Exp Date:	
Family Physician:		Address/Tel:	

Does patient have a diagnosis: _____ Yes _____No Please specify: _____
Date of diagnosis: _____ Cause/Relevant History: _____
Is this injury caused by: Motor Vehicle Accident____ Yes ____No Workplace accident? ____ Yes ____No
Claim/File # (if applicable) _____

Primary Problem: (Please check one and circle which side of the body)

- □ Hip Right/Left
- □ Shoulder Right/Left
- □ Foot/Ankle Right/Left
- □ Knee Right/Left
- □ Elbow Right/Left
- □ Wrist Right/Left
- □ Low-back Right/Left
- □ Mid-back Right/Left
- □ Neck Right/Left
- □ Other _____

Duration of Symptoms:	
Investigations to date:	CT Scan _____ MRI _____ X-Ray _____ Ultrasound_____

Treatment to date:

- □ Analgesics/Narcotics
- □ NSAIDS
- □ Physiotherapy
- □ Joint Injections

Referring Physician Information/Comments		
Name:		
Address:		
Phone:		Fax:

Comments:

Signature: Date: