footbridge
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PLEASE FAX THIS FORM TO 778-945-6775

Referral Form

Date: _____

Patient Name: _____
DOB: _____ PHN: _____

Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Cell Phone: _____

Email Address: _____ **MSP ICBC WCB Other**

Referring Physician: _____ Billing #: _____ Phone #: _____

Family Physician: _____ Billing #: _____ Phone #: _____

REASON FOR REFERRAL: ☐ LEFT ☐ RIGHT

- ☐ Ankle Pain
- ☐ Foot Pain
- ☐ Foot Deformity
- ☐ Toe Deformities
- ☐ Ankle Instability
- ☐ Bunion
- ☐ Diabetic Foot
- ☐ Other:
- ☐ Plantar Fasciitis
- ☐ Tendon Ruptures
- ☐ Tendonitis

MEDICAL HISTORY:

- ☐ CAD
- ☐ Diabetes
- ☐ COPD
- ☐ MI Date__/__/__
- ☐ HIV Positive
- ☐ Sleep Apnea
- ☐ DVT
- ☐ Hepatitis
- ☐ Smoker
- ☐ PE
- ☐ Alcoholism
- ☐ Other:_____

Previous Surgeries: _____

Allergies: _____

Medication List: _____

Referring Physician Signature: _____ Date: _____

1. **Please attach ALL relevant Consult Reports**
2. **Please attach ALL relevant Radiology or Lab reports**