



Patient Information

<p>Referring Doctor Clinic</p> <p><i>stamp can be placed on far right.</i></p>	<p>MSP number:</p> <p>Physician name:</p> <p>Clinic information / fax:</p>
<p>Patient Data</p> <p><i>Clinic label can be placed on far right.</i></p>	<p>First name(s):</p> <p>Last name(s):</p> <p>Preferred name(s):</p> <p>Legal gender (Male Female Unspecified Other):</p> <p>Preferred pronouns:</p> <p>DOB (YYYY-MM-DD):</p> <p>PHN:</p>
<p>Patient Contact Information</p> <p><i>Please do not cover this section with any labels</i></p>	<p>Email:</p> <p>Mobile number:</p> <p>Address:</p> <p>City:</p> <p>Postal code:</p>



Patient Referral

<p>Referring to</p> <p>For more information about our physicians, those registered with pathways can view our clinic at https://pathwaysbc.ca/clinics/318</p>	<p>First Available Physician <input type="checkbox"/> (Referral mandatory)</p> <p>Specific Sports Medicine Physician: (Referral mandatory)</p> <p>Dr. Robert Drapala <input type="checkbox"/> Dr. Michael Koehle <input type="checkbox"/> Dr. Donald McKenzie <input type="checkbox"/> Dr. Michael Orenstein <input type="checkbox"/> Dr. Robert Petrella <input type="checkbox"/> Dr. Navin Prasad <input type="checkbox"/> Dr. Mark Roberts <input type="checkbox"/> Dr. Ahmed El Sayed <input type="checkbox"/></p> <p>IMS Physiotherapists (Referral not mandatory)</p> <p>Ms. Lyndal Solomons <input type="checkbox"/> Ms. Joanne McBrinn <input type="checkbox"/></p> <p>Performance Nutritionist (Referral not mandatory)</p> <p>Mr. Alan Kenny <input type="checkbox"/></p>
<p>Injury</p>	<p>Date of injury (yyyy-mm-dd):</p> <p>Is this a sports related injury: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Is this an ICBC / WCB Case?</p> <p>ICBC <input type="checkbox"/> WCB <input type="checkbox"/> Neither <input type="checkbox"/></p> <p>WCB Claim Number (8 digits):</p>
<p>Please fax all relevant imaging reports and investigations with the referral.</p> <p>Our clinic does NOT accept referrals for: non-sport related head and neck injuries, or fibromyalgia / wide-spread pain complaints.</p> <p>This referral form must be complete with all information. Incomplete referral forms will be returned.</p>	<p>List the body part involved:</p> <p><i>For multiple body parts / patient complaints, please send separate referrals.</i></p> <p>Relevant History:</p>