



DON VALLEY

Health and Wellness

Physical Therapy & Rehabilitation Centre

Date:

PATIENT INFORMATION

Name:

Phone:

Diagnosis / Recommendations:

REQUISITION

- Physiotherapy and Rehabilitation Program (with orthopedic surgeon / lower extremity consultation*)**

* To be arranged further to a comprehensive assessment or at program completion if clinically indicated.

SERVICES & PROGRAMS

- | | |
|--|--|
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> MVA Rehabilitation (Motor Vehicle Accident) |
| <input type="checkbox"/> Chiropractic | <input type="checkbox"/> WSIB Rehabilitation |
| <input type="checkbox"/> Massage Therapy | <input type="checkbox"/> Osteoporosis / Bone Strengthening |
| <input type="checkbox"/> Osteopathy | <input type="checkbox"/> Arthritis / Early Intervention OA |
| <input type="checkbox"/> Naturopathy / Acupuncture | <input type="checkbox"/> Counseling / Social Worker |
| <input type="checkbox"/> Chiropody / Foot Care | <input type="checkbox"/> Pregnancy Pre & Post Natal Care |

ORTHODEDIC DEVICES & SURGICAL SUPPLY

The following items are medically necessary and for daily use. No other method of correction will do.

- | | |
|---|--|
| <input type="checkbox"/> Custom Orthotics | <input type="checkbox"/> Compression Socks / Stockings |
| <input type="checkbox"/> Off the shelf Orthopedic Shoes | <input type="checkbox"/> 20-30 mmHg |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> 30-40 mmHg |
| <input type="checkbox"/> Brace / Splint | |

Referring Physician's Signature

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