



# The Ability Clinic

Bone • Muscle • Nerve

755 Queensway East, Suite 304  
Mississauga, ON, L4Y 4C5

## Referral Form

Thank you for choosing The Ability Clinic. Please fill out this form to ensure that your patient receives the appropriate care. All information is *Private and Confidential*.

### Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
YYYY - MM - DD

Mobile: \_\_\_\_\_ Phone: \_\_\_\_\_

### Referring Physician Information

Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_  
YYYY - MM - DD

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

OHIP Number: \_\_\_\_\_ Signature: \_\_\_\_\_

Physician Requested:  First available  Specific request \_\_\_\_\_

#### Consultation and Service(s) Requested:

- |   |  |
|---|--|
| <input type="checkbox"/> Musculoskeletal Consultation     | <input type="checkbox"/> Neurology Consultation                    |
| <input type="checkbox"/> Exercise Counseling              | <input type="checkbox"/> Rheumatology Consultation                 |
| <input type="checkbox"/> US-Guided Injection Consultation | <input type="checkbox"/> Electrodiagnostics Consultation (EMG/NCS) |

*Presumptive diagnosis and additional information:*

Investigations Attached:  Ultrasound  X-Ray  CT  MRI  EMG  Labs  Other

Please return by Fax: **(905) 826-7201** or E-mail: [referrals@abilityclinic.ca](mailto:referrals@abilityclinic.ca)