Kinesis
Physical Medicine and EMG

Kinesis Medical Centre
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MSK Physiatry Assessment

Patient Information

Last Name: _____
First Name: _____
Address: _____
City: _____
Province: _____
Postal Code: _____
Email: _____
Home Phone Number: _____
Work Phone Number: _____
Cell Phone Number: _____
Gender: _____
Date of Birth: _____
Personal Health Number: _____

Referring Clinic Information

Clinic Name: _____
Referring Physician Name: _____
PRAC ID: _____
Address: _____
_____
City: _____
Province: _____
Postal Code: _____
Phone Number: _____
Fax Number: _____
(If different than above)
Family Physician Name: _____
PRACID: _____

Service(s) Requested:

If you are uncertain of the clinic your patient requires, the default is a Physiatry Consultation.

- ☐ Acute MSK Injury Consultation
- ☐ Pediatric Sport Injury Consultation
- ☐ Adult Sport Injury Consultation
- ☐ Physiatry Consultation
- ☐ Arthritis Consultation
- ☐ Ultrasound Guided Injection & Consultation

WCB Claim Number: _____ **Symptom Onset:** _____

Failure to include will result in the referral being declined.

Include all relevant imaging / investigations and/or consultation reports

Xray ☐ **U/S** ☐ **MRI** ☐ **CT** ☐ **Consult Report** ☐

Reason for Assessment:

If additional space is needed, please include a separate referral letter.