Fraser River Rehabilitation

#202 - 7084 Vedder Rd, Chilliwack, BC

Please send referrals by email or fax

email: info@fraserriverrehab.com

fax: 778-720-5575

PHYSIOTHERAPY and VESTIBULAR THERAPY - REFERRAL FORM

CLIENT INFORMATION:

NAME: _____ PHN: _____
Last First Middle

DATE OF BIRTH: _____ • client must be ≥ 16 years of age Male ☐ Female ☐
dd/mm/yy

CURRENT ADDRESS: _____

PHONE NUMBER: _____ FAMILY DOCTOR: _____
Phone #

ONSET OF SYMPTOMS (approximate date): _____

IS THERE A HISTORY OF CONCUSSION OR FALLS?: Y _____ N

DESCRIPTION OF SYMPTOMS: _____

_____

_____

SYMPTOM CHECKLIST:

DIZZINESS/VERTIGO	Y	N	ARM PAIN	L	R
HEADACHES/MIGRAINES	Y	N	UPPER BACK PAIN	Y	N
BALANCE ISSUES	Y	N	LOWER BACK PAIN	Y	N
NECK PAIN	Y	N	LEG (Incl. Hip) PAIN	L	R
SHOULDER PAIN	L	R	KNEE PAIN	L	R

ADDITIONAL INFORMATION:

ANY SCANS OR INVESTIGATIONS COMPLETED? Y N

IF YES, TYPE OF TESTING AND RESULTS: _____

PERSON MAKING REFERRAL:

NAME/TITLE: _____
(Please print first and last name) Billing #

CONTACT INFORMATION: _____

HAS CLIENT BEEN INFORMED OF REFERRAL: Y N

SIGNATURE (Person completing form): _____ DATE: _____