Rehab, Pain Management and Wellness Care

Dr. P. F. Liang MD, Dr. Ac., DC

MD REFERRAL FORM

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Patient Name:

Reason for Referral/Diagnosis:

Presenting Complaint(s):

Region:
- ☐ Headaches
- ☐ Neck Pain
- ☐ Thoracic
- ☐ Lumbar
- ☐ Pelvis
- Extremity
  - ☐ Upper
  - ☐ Lower
- ☐ Other health conditions: _____

Onset:
- ☐ Sudden
- ☐ Insidious
- ☐ Progressive

Type:
- ☐ MVA
- ☐ WSIB
- ☐ Trauma

Pain Duration:
- ☐ Acute
- ☐ Sub-acute
- ☐ Chronic

Associated S/S:
- ☐ Dizziness
- ☐ Headaches
- ☐ Weakness
- ☐ Tingling

Type of Therapy Recommended:
- ☐ Acupuncture Therapy
- ☐ Active Rehabilitation Exercise
- ☐ Chiropractic Treatment
- ☐ Registered Massage Therapy
- ☐ Orthotics/Orthopaedic Brace (*Hand /Knee /Ankle*)

Physical therapy Modalities: ☐ Ultrasound ☐ TENS ☐ IFC ☐ Laser

Clinical Record/Commends:

(*Red Flags and Past Medical history; Investigations; Medications; Yellow Flag/Psychosocial factors*)

Confidential Information to Follow: ☐ By phone ☐ By Fax ☐ By Mail

Physician's Name:

Address: Phone:

Signature: Date: