

MD REFERRAL FORM

Chiropractic Office:

Subject ID: _____

Patient Information

Patient name:

Family Physician:

Reason for Referral / Diagnosis

Presenting Complaint(s)

Please ✓ appropriate Box(es). Add additional information if required.

Region:

- Headaches
- Neck Pain
- Thoracic
- Lumbar
- Pelvis
- Extremity
- Upper - Lower

Onset:

- Sudden
- Insidious
- Progressive

Type:

- MVA
- WSIB
- Trauma

Pain Duration:

- Acute
- Sub-acute
- Chronic

Associated S/S:

- Dizziness
- Headaches
- Weakness
- Tingling

Clinical Record

Red Flags and Past Medical History

Investigations

Medication

Yellow Flags (psychosocial factors)

Comments

CONFIDENTIAL INFORMATION TO FOLLOW:

By Phone

By Fax

By Mail

Physician's Name:

Address:

Signature:

Phone:

Date:

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