Community Therapy
SERVICES

REQUEST FOR PHYSIOTHERAPY CONSULTATION

Please tick the ASAP box if resident has suffered a recent fracture &/or surgical repair of a fracture

ASAP ☐

Name of PCH: _____ **PCH Phone #:** _____

Name and designation of person making the referral: _____

Reason for Referral/Services Requested: _____

_____

_____

_____

Relevant History: _____

_____

_____

Additional Comments: _____

_____

_____

Physician's Name. _____ **Date Faxed to CTS:** _____

PLEASE FAX COMPLETED FORM TO

(204)942-1428

COMMUNITY THERAPY SERVICES
101 – 1601 Buffalo Place Winnipeg, MB R3T 3K7
949-0533