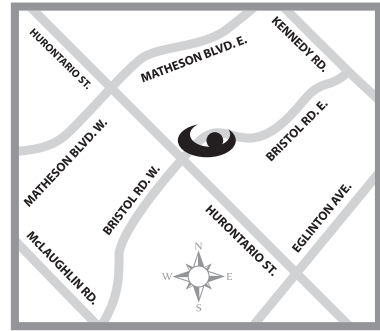


m i s s i s s a u g a



INTEGRATIVE MEDICAL REHABILITATION CENTRE

www.mississaugawellness.com



unit 4, 60 bristol road e., mississauga, on L4Z 3K8
phone: 905-501-0035 • fax: 905-501-0039

REFERRAL FORM

patient name: _____ D.O.B. _____

diagnosis: _____

reason for referral:

- physiotherapy
- motor vehicle accident
- sports injury
- work injury
- massage therapy
- chiropractic consultation

- podiatry consultation
- custom orthotics
- orthopedic shoes
- compression stockings
- naturopathic consultation
- acupuncture

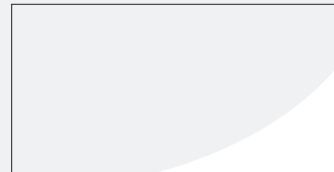
comments:

signature: _____

name: _____

date: _____

STAMP



THE DESIGNERS PRINTING

Tel: **905-388-0748** • Fax: **905-388-4122** **PROOF**

Please check CAREFULLY, and sign this proof.
We are NOT responsible for ANY errors or omissions after this proof is approved.

1 OK as is _____
(Proceed to step 2)

OK with changes _____
(Proceed to step 2)

Another proof required _____

2 Spelling/Grammar OK _____

*** PLEASE FAX BACK TO: 905-388-4122 ***