Mobility Clinic
THE CENTRE FOR FAMILY MEDICINE

Initiative for Cervical and Breast Cancer Screening for Patients with Disabilities

Please fax this completed referral form, patient profile and any relevant investigations and/or consultation reports to **519-578-2109**

We also accept electronic referrals through Ocean eReferral

PATIENT INFORMATION	
Name:	Date of Birth (yyyy/mm/dd):
Health Card Number:	
Street Address:	
City:	Postal Code:
Home Phone Number:	Work/Cell Phone Number:
Alternative Contact:	Relationship:
Home Phone Number:	Work/Cell Phone Number:

Diagnosis/Medical History:

Reason for Referral:

- ☐ General assessment
- ☐ Bowel/Bladder
- ☐ Pain/Spasticity
- ☐ Skin breakdown/wounds
- ☐ Initiative for Cancer Screening

☐ Other: *(please specify)*

Does the patient require a mechanical lift to transfer: ☐ yes ☐ no

PRIMARY CARE PROVIDER:		
Name:	Billing #:	Date (yyyy/mm/dd):
Phone #:	Fax No:	

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