PATIENT REFERRAL FORM

45 King Street , Hamilton, HM19, Bermuda | 441-238-6824 | 441-238-6825 | office@intouch.bm

*** Please write **clearly** as to avoid delay in scheduling appointments. Thank you. ***

Patient Name: _____

Date of Birth: _____ Insurance Provider: _____

Phone Numbers: _____ (Home) _____ (Business)

_____ (Cell)

DIAGNOSIS:_____

_____

PAST MEDICAL HISTORY: _____

_____

_____

PRECAUTIONS:_____

Tick Required Service: ☐ Physiotherapy ☐ Occupational Therapy ☐ Hand Therapy

☐ Lymphedema ☐ Oncology Rehabilitation ☐ Other _____

REASON FOR REFERRAL: ☐ Evaluate and Treat ☐ MLD/CDT ☐ Compression Garments

☐ Splint _____ ☐ Other: _____

Next Appointment with Doctor: _____

IS CLIENT AWARE OF REFERRAL? ☐ **YES** ☐ **NO**

Doctor's Printed Name: _____

Doctor's Signature: _____

Date: _____