CMC | CORNERSTONE MEDICAL CLINIC

#100-415 Wellman Crescent
Saskatoon, SK, S7T 0J1
Ph 306-975-1262 Fax 306-975-1221

MUSCULOSKELETAL HEALTH REFERRAL FORM

Dr. Sarah Williams

PATIENT INFORMATION

Surname: _____ First Name: _____
Birthdate: ___/___/_____ (DD/MM/YYYY) PHN: _____
Address: _____ Phone: _____
_____ Alt Phone: _____

REFERRING PRACTITIONER INFORMATION

☐ Family Doctor
☐ Specialist
☐ Nurse
☐ Other: _____

Referring Practitioner: _____
Clinic: _____
Address: _____
Phone: _____ Fax: _____

URGENCY OF REFERRAL: ___ URGENT ___ ROUTINE

REASON FOR REFERRAL: (please include copies of all relevant images, labs, consults)

☐ general musculoskeletal complaint, specify: _____
_____

☐ evaluation of sport-related injury, specify: _____
_____

☐ pelvic floor concerns (Dr. Sarah Williams, Dr. Carly Conly), specify: _____
_____

☐ joint injections (Dr. Sarah Williams, Dr. Jacqueline Bucko), specify joint: _____

Clinical information:

_____
_____
_____
_____
_____

Practitioner Signature: _____ Date: ___/___/_____ (DD/MM/YYYY)

Please fax referral to 306-975-1221

For more information, please visit our website at www.cornerstonemedical.ca