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 Referring Practitioner: _____

☐ Specialist Clinic: _____

☐ Nurse Address: _____

☐ Other: _____ 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