Wellington hand clinic

Medicine & Occupational Therapy • Specialized Hand/Wrist Therapy

Patient Name: _____

Address: _____

_____

Phone # _____

DOB: _____

(Affix Label if Available)

❑ PT Referral ❑ OT Referral ❑ Both

Diagnosis: _____

_____

Surgical Date: _____

Surgery: _____

Treatment Requested: _____

_____

❑ Therapist's Discretion

❑ Splint/Brace Only Type: _____

Contraindications/Precautions: _____

_____

Payment Plan: ❑ Extended Health ❑ WSIB ❑ MVC ❑ Other

Date: _____

Physician Signature: _____

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Guelph, Ontario N1H 3R7
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Fax: 519-824-4876
www.wellingtonhandclinic.com

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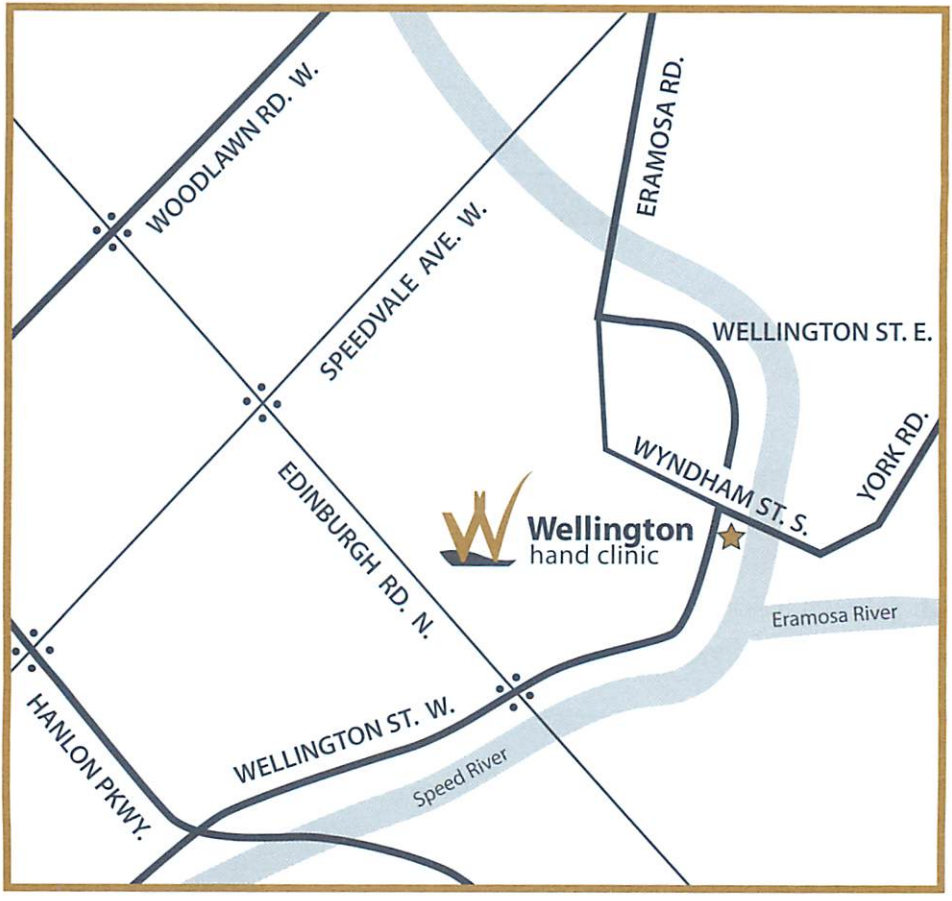

FREE PARKING