MEDILINK CONSULTING CENTER

All medical services under same roof

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www.medilinkconsulting.ca

NURSING FOOT CARE REFERRAL FORM

Name _____ Date _____

Address _____ Emergency contact _____ Phone _____

CONTACT NUMBER

Home: _____

Work: _____

Mobile: _____

E-mail: _____

Can we leave messages on this number?

Yes No

Yes No

Yes No

MODALITY OF PAYMENT:

Extended Medical Benefit (Name & Plan) ◯ _____

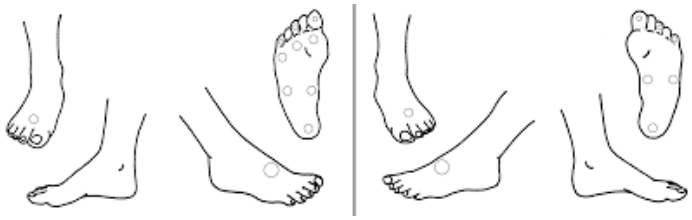
Private ◯ _____

Others: (ICBC, WCB..., Claim number) ◯ _____

YOUR PROBLEM:

- ◯ Motor Vehicle accident
- ◯ Work related injury
- ◯ Sport injury
- ◯ Post injury
- ◯ Other: (Please indicate here)

Please indicate on the diagram where you feel the pain



Please describe your problem in few words:

_____

WHEN DID IT START? _____

SCALE THE PAIN: 1-10 (10 being the highest)

◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯ ◯

1 2 3 4 5 6 7 8 9 10

Since it began, is it: ◯ Improving ◯ The same ◯ Worsening

Is the problem new? ◯ New ◯ Long standing ◯ Recurrent

Patient signature/ initials: _____ Date: _____

OR

Guardian signature/ initials: _____ Date _____