



**PHYSICAL MEDICINE AND REHABILITATION  
DOROTHY ORT CLINIC**

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MD, FRCPC MD, FRCPC

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Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Telephone \_\_\_\_\_  
D.O.B. \_\_\_\_\_  
HC # \_\_\_\_\_

Assessment Destination:  
Inpatient   
Outpatient   
Date \_\_\_\_\_  
Referring MD \_\_\_\_\_

Reason for referral:

Please direct follow up recommendations to: Referring Physician   
Family Doctor   
Other \_\_\_\_\_