Phone: 250.763.6322
Fax: 250.712.4968

evolve ALLIED HEALTH

Evolve Allied Health Physician Referral Form – Sports Medicine

Patient Information: (affix label or complete) Name: PHN: DOB: Gender: Address: Home Phone: Alternate Phone: Email: Secondary Contact: **WCB Claim #** (if applicable)	**Referring Physician:** (affix label or complete) Name: MSP: Address: Phone: Fax: Walk-in Clinic Name: (if applicable) **Family Doctor:** (if different than above) **Date of Referral:**
Duration of Symptoms: ☐ < 6 weeks ☐ > 6weeks	**Severity of Symptoms:** ☐ Mild ☐ Moderate ☐ Severe
Location: ☐ Hip ☐ Knee ☐ Foot/Ankle ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Other	
URGENT REFERRALS: Referring physician please contact the clinic directly.	
Reason For Referral: (include diagnosis & treatment to date, including any imaging) ☐ Letter Attached	
Medical & Surgical History: ☐ History Attached	**Medications:** ☐ List Attached
	Allergies: ☐ List Attached

Receipt of referral will be confirmed via fax to the referring physician's office upon review and an approximate wait for the appointment will be indicated. Patients will be contacted by our office to schedule an appointment and the referring physician will be advised of the appointment date once scheduled, via fax.