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CHIROPRACTIC REFERRAL FORM

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Cell Phone: _____

CLINICAL INFORMATION

- | | | | |
|--|--|---|-----------------------------------|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Mid-Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headache |
| <input type="checkbox"/> GLA:D Back Program Complimentary 15 Minute Video Consultation | | <input type="checkbox"/> 1:1 Chiropractic Care Complimentary 15 Minute Video Consultation | |
| <input type="checkbox"/> Other | | | |

Relevant History and Examination: (include any relevant investigations, imaging studies, consults)

REFERRAL INFORMATION

Referring Physician Name: _____

PRAC ID: _____

Clinic Address: _____

Phone: _____

Fax: _____

Referring Physician Signature: _____

Date: _____

Please fax completed referral to 403-775-4212 OR email via Brightsquid Secure-Mail