Vancouver Spine & Disc Centre

Dr. Peter Ting BSc DC
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VANCOUVER, BC
V6Z 1S4
604-689-4325

# PATIENT REFERRAL FORM

## Patient Information

| | | |
|---|---|---|
| Last Name | Given Name | Age |
| Sex ( M / F ) | Date of Birth (MM/ DD/ YYYY) | |
| Address | City | |
| Province | Postal Code | Home Phone |
| Work Phone | Health Care Number | |

## Clinical History

Any communicablle infection known or suspected please indicate;

| Exam | Yes | When | Where |
|---|---|---|---|
| MRI | | | |
| CT | | | |
| X-RAY | | | |

Others: _____

*Please fax all reports with requisition*

## Physician Information – Please Include Signature

| | | |
|---|---|---|
| Physician | Phone | Fax |
| Address | City | |
| Province | Postal Code | |
| Copy to | Phone | Fax |
| Physician Signature | Date | |

## Booking Instructions

**1, We will contact your patient and book the appointment after receiving the requisition.**

*** More detailed screening with the patient will be conducted over the phone prior to appointment booking.**