



**HEALTH BOUND**  
HEALTH NETWORK

**PATIENT REFERRAL FORM**

TEL 416-548-7872  
FAX 416-850-9609  
EMAIL [info@healthbound.ca](mailto:info@healthbound.ca)  
[www.healthbound.ca](http://www.healthbound.ca)

☐ **EAST YORK**

909 Pape Ave, Suite 1  
East York ON M4K 3V1  
T 416-519-3775

☐ **BLOOR WEST**

3250 Bloor St W, Suite 111  
Toronto ON M8X 2X9  
T 416-236-7778

☐ **MARKHAM**

4331 14th Ave, Suite 1  
Markham ON L3R 0J2  
T 416-850-8558

☐ **BARRIE**

65 Bell Farm Rd,  
Barrie ON L4M 5G1  
T 647-477-7057

- ☐ Ajax
- ☐ Amherstview
- ☐ Barrie
- ☐ Bolton
- ☐ Brampton
- ☐ Brantford
- ☐ Burlington
- ☐ Cambridge
- ☐ Dunnville
- ☐ East York
- ☐ Etobicoke
- ☐ Guelph
- ☐ Hagersville
- ☐ Kingston
- ☐ Kitchener
- ☐ Markham
- ☐ Milton
- ☐ Mississauga
- ☐ Newmarket
- ☐ North York
- ☐ Oakville
- ☐ Orangeville
- ☐ Peterborough
- ☐ Richmond Hill
- ☐ St. Catharines
- ☐ Thornhill
- ☐ Toronto
- ☐ Vaughan
- ☐ Wasaga Beach
- ☐ Other:

PATIENT NAME

DATE OF ACCIDENT

ADDRESS

TELEPHONE

PHYSICIAN NAME

TELEPHONE

DIAGNOSIS

☐ MVA ☐ WSIB ☐ EHC ☐ SLIP & FALL ☐ PRIVATE

**SERVICES / TREATMENT**

- ☐ PHYSIOTHERAPY
- ☐ OCCUPATIONAL THERAPY
- ☐ CHIROPRACTIC
- ☐ ACUPUNCTURE
- ☐ NATUROPATHIC
- ☐ MASSAGE THERAPY / CUPPING
- ☐ ACTIVE EXERCISE / PERSONAL TRAINING
- ☐ CHIROPODY / FOOT CARE
- ☐ MSK INJECTIONS / PRP
- ☐ PSYCHOLOGICAL COUNSELING

**PROGRAMS OF CARE**

- ☐ OUTPATIENT REHABILITATION
- ☐ COMMUNITY REINTEGRATION
- ☐ TRAUMA & FRACTURES
- ☐ BRAIN INJURY PROGRAM
- ☐ SPINAL CORD INJURY PROGRAM
- ☐ HYDROTHERAPY PROGRAM
- ☐ CONCUSSION PROGRAM
- ☐ VESTIBULAR REHABILITATION
- ☐ COGNITIVE FUNCTIONAL
- ☐ CHRONIC PAIN PROGRAM

**ASSISTIVE DEVICES / EQUIPMENT / HOME HEALTHCARE**

- ☐ BONE GROWTH STIMULATOR
- ☐ COLD COMPRESSION THERAPY
- ☐ CONTINUOUS PASSIVE MOTION DEVICE
- ☐ CUSTOM MADE ORTHOPEDIC BRACES
- ☐ CUSTOM MADE ORTHOTICS / SHOES
- ☐ COMPRESSION HOSIERY
- ☐ ERGONOMIC / POSITIONING DEVICES
- ☐ MOBILITY DEVICES
- ☐ HOME SAFETY DEVICES
- ☐ HOME / VEHICLE MODIFICATION
- ☐ PERSONAL CARE / HOME MAKING
- ☐ NURSING / COMPANION SERVICES

*I give my consent to release my personal contact and health information to the Health Bound Health Network for the provision of the above-mentioned treatment and services.*

PATIENT SIGNATURE

DATE



**Proudly Accredited  
by CARF**