Referral Form – The Care Clinic at Perley Health
Fax #: 613-526-7126

Client's Personal Information

First name	Last name	Date of birth (dd/mm/yyyy)	Primary phone #
Address (unit, street#, street name)	City	Postal code	Province
Email		DVA/K# (if applicable)	

Substitute Decision-Maker (if applicable)

First name	Last name	Relationship to client	Primary phone #

Reason for Referral

Audiology:
☐ Hearing assessment (children/adults)
☐ Infant hearing screening (0-6 months)
☐ Hearing aid evaluation/follow-up
☐ Hearing sensitivity
☐ Tinnitus
☐ Auditory Processing Disorder
☐ Earwax/cerumen removal
☐ Other:

Registered Massage Therapy:
☐ Massage therapy assessment and treatment

Foot Care:
☐ Thick, long toenails ☐ Corn(s), calluses
☐ Ingrown toenail(s) ☐ Other:

Physiotherapy:
☐ Rehabilitation
☐ Pain management
☐ Vestibular therapy
☐ Mobility aid assessment - walker
☐ Concussion management
☐ TMJ dysfunction/headache management
☐ WSIB
☐ MVA
☐ Other:

Speech Therapy:
☐ Stuttering assessment/treatment
☐ Cluttering assessment/treatment
☐ Speech sound articulation assessment/treatment
☐ Other:

History of diabetes? ☐ yes ☐ no
Anti-coagulant medication? ☐ yes ☐ no If yes, please specify:

Additional Notes:

Referring Healthcare Provider

First name	Last name	Phone #

Family Doctor

First name	Last name	Phone #