Minor Injury, Soft Tissue Rapid Evaluation And Management Clinic (MI-STREAM)

Referral Form

Please Fax To: 416-603-5406

Client Information

Patient Addressograph:

Name: _____

DOB: ____ / _____ / _____

HC#: _____ _____

Best Contact Number (_____) - _____ - _____

Referring Physician/NP:

OHIP Billing No:

Physician Address:
☐ TWH ED ☐ TGH ED ☐ Family MD ☐ Fracture Clinic
☐ Other: _____

Phone Number:

Fax Number:

Interpreter Required:
☐ Yes ☐ No

Language:

Reason for Referral:

☐ Concussion (**Injury <4mo**)
☐ Concussion Severity Score Sheet

☐ Acute Back Pain **(<3mo)**

☐ Lower Extremity

☐ Upper Extremity

Area of Injury: _____

Date of Injury: if applicable (DD/MM/YYYY): _____

Brief History:

_____

_____

_____

_____

_____

Referral For:
☐ MI-STREAM Clinic (OHIP Covered)

Non-OHIP Services
☐ Physiotherapy/Acupuncture
☐ Massage Therapy
☐ Chiropractor

Extended Health Benefits? ☐ Yes ☐ No

Is this a WSIB Claim? ☐ Yes

Is this a Medicolegal or Motor Vehicle Accident case? ☐ Yes *(We **DO NOT** accept referrals to MI-STREAM for medicolegal cases)*

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