AMPUTEE CLINIC REFERRAL FORM
FAX TO: (705) 745-7307

210 Hunter Street, Unit 1, Peterborough, ON K9H 2L2 Telephone: (705) 745-1341

CLIENT INFORMATION

☐ Female ☐ Male

Name ______________________ DOB (MM/DD/YYYY) ______________

Street ______________ City/Town ______________ Postal Code ______________

Health Card Number ______________________ Telephone Number ______________

Diagnosis: ____

Amputation Date(MM/DD/YYYY) ______________________ Amputation Type and Level ______________

☐ Left ☐ Right

REFERRAL SOURCE

Referring Physician ______________________ Telephone ______________

Referring Physicians Signature ______________________ Fax Number ______________

Referral Date (MM/DD/YYYY) ______________________

Please forward any pertinent reports