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REFERRAL: ODSTOCK DROP FOOT STIMULATOR

PLEASE FAX TO : 604-922-2790

Date of Referral: _____
Referring Practitioner: _____
Contact Phone: _____

PATIENT PROFILE

Patient Name: _____ Address: _____

Date of Birth: ____ / ____ / ____

Home phone: ____ - ____ - ____ Cell phone: ____ - ____ - ____

E-mail : _____

Diagnosis : _____ Date of onset of condition: ____ / ____ / ____

Diabetic: Yes No

Medical History: _____

Ambulation status

Fully independent : Yes No

If No, briefly describe assistance required: _____

Uses Wheelchair : Yes No

Other findings relevant to this referral: _____

Practitioner Signature