Reset Form

ARTHRITIS & INJURY CARE
BRACING & ORTHOTICS

Orthotist Consultation Request

PATIENT INFORMATION:

Name

Date of Birth

Phone 1 | Phone 2

Health Card No.

Address

REFERRING PROFESSIONAL:

Name

Fax No.

Phone No.

Request Date

Case Type ☐ WCB ☐ MVA ☐ Community Services ☐ N/A

LOCATION:

☐ **DOWNTOWN HALIFAX**
Park Lane Mall
1554 Dresden Row, Suite 3070 Halifax, NS B3J 2K2
PHONE: 902-442-5199 **FAX** 902-442-5625

☐ **CLAYTON PARK**
Ravine Centre One
36 Solutions Drive, Suite 105, Halifax NS B3S 1N2
PHONE: 902-404-8419 **FAX** 902-442-5625

PATIENT DIAGNOSIS:

REASON FOR REFERRAL:

☐ Ankle Foot Orthosis (AFO)

☐ Knee Ankle Foot Orthosis (KAFO)

☐ Other: _____

SPECIALIST:

☐ **DOUG IWASAKI** Certifed Orthotist

☐ Cranial Remolding Orthosis (Baby Helmets)

☐ Bioness Foot Drop System

ADDITIONAL INFORMATION:

Past Medical History

Medications

Allergies

REFERRING PROFESSIONALS SIGNATURE: _____

Please attach all pertinent documents and fax to 902-442-5625 or email to contact@arthritisandinjurycare.com

P 902.442.5199 | Toll Free 1.888.422.1608 | F 902.442.5625
www.arthritisandinjurycare.com