DIVERGENT
INNOVATIVE HEALTH CARE

REFERRAL FORM

8835 Macleod Trail Southwest, Suite 240 Calgary, Alberta, T2HoM2
Phone: (587) 325-0253
Fax: (587) 324-4196

PATIENT INFORMATION:

Patient Name: _____ **AHC #:** _____

Date of Birth: _____ **Phone:** _____

Area of Injury: _____ ☐ **Left** ☐ **Right**

Mechanism of Injury: _____

_____

Related History: _____

Diagnosis: _____

Existing Medical Reports Attached: ☐ **Yes** ☐ **No**

Imaging: _____

DISCIPLINES

- ☐ SPORT INJURIES
- ☐ MASSAGE THERAPY
- ☐ PHYSIOTHERAPY
- ☐ KINESIOLOGY
- ☐ CHIROPRACTIC
- ☐ MEDICAL

PROGRAMS & SERVICES

- ☐ Foot & Ankle pain
- ☐ Neck & Back pain
- ☐ Headache
- ☐ Shoulder Pain
- ☐ Wrist and Elbow pain
- ☐ Knee & Hip pain
- ☐ Custom bracing & Orthotics
- ☐ Cortisone or Trigger Point Injection

SPECIFIC INSTRUCTIONS: _____

_____

PHYSICIANS NAME: _____ **PRAC ID:** _____

SIGNATURE: _____ **DATE:** _____

www.divergenthealth.ca info@divergenthealth.ca

- Fax the Referral Form and our Patient Coordinator will contact patient or
- Patients will inquire at info@divergenthealth.ca