



PROSTHETICS
BRACING
ORTHOTICS

100-115 BELL FARM ROAD
BARRIE, ON L4M 5G1
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PBOGROUP.CA

REQUEST FOR CONSULTATION WITH DR. HILARY KLASSEN M.D. FRCPC FOR AMPUTEE CLINIC
AMPUTEE CLINIC | FAX: 705-725-7313

CLIENT INFORMATION

Female **Name:**

Male **Date of Birth:**
MM/DD/YYYY

Street Address:

City/Town: Postal Code:

Health Card Number: Telephone Number:

Reason for Amputation (Diagnosis):

Level of Amputation: Below Knee Above Knee Partial Foot Below Elbow Above Elbow

Side of Amputation: Left Right

Date of Amputation: MM/DD/YYYY Amputation Surgeon:
please print clearly

Relevant Medical History:

Current Prescribed Medications:

Referring Physician: please print clearly OHIP Billing #:

Signature: Date:
MM/DD/YYYY

THIS FORM MUST HAVE ALL INFORMATION COMPLETED