



PROSTHETICS
BRACING
ORTHOTICS

547 GLENRIDGE AVENUE
ST. CATHARINES, ON L2T 4C2
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PBOGROUP.CA

AMPUTEE CLINIC REFERRAL FORM
FAX: 905-688-3230 | Email: niagarahds@pbogroup.ca

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):

Date of Amputation: Amputation Type and Level:
MM/DD/YYYY

Left Right

REFERRAL SOURCE

Referring Physician: Telephone:

Signature: Fax:

Referral Date:
MM/DD/YYYY

****PLEASE FORWARD ANY PERTINENT REPORTS****

SUBMIT FORM