



**PROSTHETICS
BRACING
ORTHOTICS**

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GENERAL REFERRAL FORM - NIAGARA GENERAL HOSPITAL SITE
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:

Diagnosis/Rx:

REFERRAL SOURCE

Name and Designation:

Telephone Number: Fax Number:

Signature: Referral Date:
MM/DD/YYYY

Notes:

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

SUBMIT FORM