



TORONTO

PROSTHETICS
BRACING
ORTHOTICS

PBO TORONTO: WEST
8-90 CLAIREPORT CRESCENT
ETOBICOKE, ON M9W 6P4

TEL: 905-624-9293

PBOGROUP.CA

**AMPUTEE/PHYSICAL MEDICINE AND REHABILITATION CLINIC REFERRAL FORM
(PROSTHETIC AND PHYSIATRY CONSULTATION)**

FAX: 289-514-1957 | Email: clientcaretorontowest@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:

Billing Number: Referral Date:
MM/DD/YYYY

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

SUBMIT FORM