ALLAN MCGAVIN
Sports Medicine
Centre
PRIMARY CARE

OFFICIAL MEDICAL CENTRE

PRIMARY CARE REFERRAL FORM

Please fax completed form (plus all applicable imaging reports) to 604-822-9058

Referring Physician

Name: ______________________________

MSP Billing #: ____________________

Fax #: __________________________

First Available ☐

Specific Physician ☐

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*****All information is this field required or the referral will be returned*****

First Name: ____________________ Last Name: ________________________ Male ☐ Female ☐

DOB: ______________________________ PHN: ____

Mobile Number: ________________________ ****Email:** ______________________@ __________

Sports related injury? Yes ☐ No ☐ Is this and ICBC/WCB Case? Yes ☐ No ☐ ICBC ☐ WCB ☐

Mailing Address: ____________________________ City: _______________ Postal Code: _________

*****Doctors at our practice only see sport-related head and neck injuries*****

Body Part Involved: ____

Relevant History: ____

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***Separate referral form per body part

***Patients will be contacted with appointment date and time. We will send a notification to the referring physician's office for their records.

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