Community Therapy
SERVICES
101-1555 St. James Street
Winnipeg, MB R3H 1B5
T: (204) 949-0533 F: (204) 942-1428

Client Name: _____
PHIN: _____
Community Name: _____
Phone #: _____
Date of Birth (dd/mmm/yyyy): _____
MHSC: _____
Sex: _____ Pronouns: _____

FIRST NATIONS PHYSIOTHERAPY PROGRAM
CONSULT FORM

Name and designation of person making the referral: _____

Services requested for/client returning to the following community: (select one)

- ☐ **Bloodvein**
- ☐ **Pauingassi**
- ☐ **Wassagamack**
- ☐ **Norway House**
- ☐ **Poplar River**
- ☐ **Red Sucker Lake**
- ☐ **Little Grand**
- ☐ **St. Theresa Point**
- ☐ **Hodgson (Percy E. Moore Hospital)**
- ☐ **Berens River**
- ☐ **Garden Hill**

Reason for Referral/Services Requested: _____

Relevant History: _____

Physician's Name: _____ **Date Faxed to CTS:** _____

PLEASE FAX COMPLETED FORM TO (204)942-1428