Dr. Dale Macdonald and Associates
ELITE SPORTPERFORMANCE

MSK INJURY/REHAB THERAPY/SPORT MEDICINE REQUISITION

PATIENT INFORMATION

Place patient label here

Date of Request D/M/Y _____ Home Ph # _____ Other Ph # _____

Name _____ ☐ Female ☐ Male

Address _____ Date of Birth D/M/Y _____

City _____ Province _____ Postal Code _____ PHN _____

HISTORY AND PRESUMPTIVE DIAGNOSIS

☐ Relevant Imaging on Netcare

☐ Telehealth Consult

For Law Firms

☐ Medicolegal Independent Opinion

Private Specialist Clinical Consult

The most appropriate exam/procedure will be performed based on the history provided by the referrer. Further exams/tests will be booked if indicated, following the initial consult.

Physician Initial _____

☐ Independent Second Opinion

CHIROPRACTIC

☐ Spinal Manipulation
☐ ART® (Active Release)
☐ Graston®
☐ Medical Acupuncture

CUSTOM BRACING/ORTHOTICS

☐ Custom Carbon Fiber Orthotics
☐ Custom Wrist Brace
☐ Custom Knee Bracing
  ☐ Ligament
  ☐ Unloader
  ☐ Tricompartmental

NATUROPATHIC MEDICINE

☐ Biochemical/Inflammatory Consult
☐ Food Sensitivity
☐ Hormone Testing
☐ Hydrodissection of Scars

IMAGE GUIDED PAIN THERAPY

☐ Viscosupplementation (Hyaluronic Acid)
(specify type) _____
☐ PRP (Platelet Rich Plasma)
☐ nSTRIDE
☐ Sportvisc
☐ Cortisone (Non-Chondrotoxic)
☐ Joint Aspiration
☐ Prolotherapy
☐ NT (Neutral Therapy)
☐ NPT (Neural Prolotherapy)
☐ Tendon Fenestration

PHYSIOTHERAPY

☐ Post Surgical Rehabilitation
☐ Surgical Pre-habilitation
☐ Objective Strength Assessment
☐ Return to Sport Clearance
☐ IMS / Dry Needling

REGISTERED MASSAGE THERAPY

☐ Therapeutic Deep Tissue Therapy
☐ Myofascial Release
☐ MVA (Motor Vehicle Accident)

REFERRER INFORMATION

NAME _____

COPY TO _____

PHONE _____ FAX _____

ADDRESS _____

PRACTITIONERS ID/STAMP

SIGNATURE _____

elitesportperformance.com

reception@elitesportsperformance.com
Ph: 403.689.9889
Fax: 403.668.4257

WE DO NOT ACCEPT WCB CASES