SHIELD SPORT MEDICINE REFERRAL

To: Dr. Wesley Armstrong MD FRCP
5065 Benson Dr, Burlington, ON L7L 5N7
Phone: 905 319 9659
Fax: 905 319 2918

PATIENT DEMOGRAPHIC INFORMATION

Full Name:	_____
Date of Birth:	_____ / _____ / _____ (DD/MM/YYYY)
Health Card # (OHIP):	_____ **Version Code:** ____
Phone Number:	_____
Email Address:	_____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____

OHIP Billing Number: _____

Clinic Name/Address: _____

Phone: _____ **Fax:** _____

REASON FOR REFERRAL

Please attach any relevant imaging to this referral.

Physician Signature: _____ **Date:** _____