**Blueberry Therapy**
PELVIC HEALTH AND PEDIATRICS

# Pelvic Health Physiotherapy Referral

## 1 PATIENT INFORMATION

First Name: ____________________ Last Name: ________________________

Address: ______________________________________________________

City: ____________________ Province: _____ Postal Code: __________

Birth Date (mm/dd/yyyy): _______________________________________

Telephone: ____________________________________________________

Family Contact (if applicable):

Name: ____________________________ Telephone: _________________

Diagnosis/Reason for Referral: ___________________________________

____________________________________________________________

Relevant Medical History: _______________________________________

____________________________________________________________

## 2 REASON FOR REFERRAL

*Check all that apply:*

- ☐ Urinary Incontinence
- ☐ Urinary Urgency / Frequency / OAB
- ☐ Pelvic Organ Prolapse
- ☐ Pregnancy Related Pain
- ☐ Dyspareunia / Vaginismus
- ☐ Vulvodynia
- ☐ Persistent Pelvic Pain
- ☐ Other (please specify): ______________________________________

____________________________________________________________

☐ Additional Information: _________________________________________

____________________________________________________________

## 3 REFERRAL SOURCE

*Please print:*

Name: ________________________________________________________

Signature: _____________________________________________________

Phone Number: __________________________________________________

Fax Number: ____________________________________________________

Date (mm/dd/yyyy): _____________________________________________


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