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: ______________________________________

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Relevant Medical History: ____

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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): ____

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- ☐ Additional Information: ____

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3 REFERRAL SOURCE

Please print:

Name: ____

Signature: ____

Phone Number: ____

Fax Number: ____

Date (mm/dd/yyyy): ____

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