



# Referral

## CLIENT

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Daytime Telephone No. 1: \_\_\_\_\_ Daytime Telephone No. 2: \_\_\_\_\_

## DIAGNOSIS / INJURY

\_\_\_\_\_  
\_\_\_\_\_

## DATE AND DESCRIPTION OF SURGERY (if applicable)

\_\_\_\_\_  
\_\_\_\_\_

## INSTRUCTIONS FOR TREATMENT AND EXPECTED OUTCOMES

\_\_\_\_\_  
\_\_\_\_\_

Referred By: \_\_\_\_\_

Clinic: \_\_\_\_\_

Preferred form of correspondence:  Email \_\_\_\_\_

Phone \_\_\_\_\_  Fax \_\_\_\_\_



**cairnshandclinic**

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*Specialist in rehabilitation of the hand, wrist & elbow*