NÜ YYC- *Referral for Regenerative Medicine Consultation with Dr. Kinaschuk*

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Referring Physician/ Practitioner:
Name:
PracID:
Practice/Clinic Name:
Phone/ Fax:

Patient Information:
Full Name:
Date of Birth:
Phone Number:
Email Address:
Health Card Number (if applicable):

Important Referral Note:

Please ensure that the patient has completed an adequate course of physiotherapy/ chiropractic rehabilitation prior to submitting the referral, unless the patient is specifically requesting Platelet-Rich Plasma (PRP) or Prolotherapy injections. Regenerative therapies may be considered in cases where conservative management has plateaued or failed.

Reason for Referral: (Please provide a brief description of the patient's condition and the reason for referral. Include details on symptoms, previous treatments, and any relevant diagnostic information such as imaging results.)

Diagnosis/Condition:

Relevant History:

Previous Treatments: (Include medications, physiotherapy, injections, or surgical interventions if applicable)

Symptoms and Duration:

Referring Physician/ Practitioner Signature:

Date: