DR. KATIE KINASCHUK
BSc. with Distinction, MD with Specialization in Research, CCFP

REFERRAL FOR REGENERATIVE MEDICINE CONSULTATION

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 prior to submitting the referral, unless the patient is specifically requesting Platelet-Rich Plasma (PRP) or Prolotherapy injections. In cases where physiotherapy has been unsuccessful or the patient has plateaued, regenerative therapies may be considered as the next step.

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: