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CHIROPRACTIC REFERRAL FORM

Patient Name:		Patient Date of Birth:	
Patient Address:			
Patient Phone:		Patient Email:	

COMPASSIONATE CARE PROGRAM (IF APPLICABLE)

The *Compassionate Care Program* is offered to assist individuals with MSK conditions who would benefit from chiropractic care but cannot afford it due to financial constraints. If you are referring to the *Compassionate Care Program*, please check the following boxes in acknowledgement:

- I certify that the above-named patient meets Canada's official definition of poverty:
"Poverty is the condition of a person who is deprived of the resources, means, choices, and power necessary to acquire and maintain a basic level of living standards"
- I certify that the above-named patient either (i) earns less than \$57,909 annually (family of four) OR (ii) less than \$28,954 annually (single individual)
**Income thresholds are based on the poverty line for Calgary, Alberta*

CLINICAL INFORMATION

- | | | | |
|---|--|---|-------------------------------------|
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Headache | <input type="checkbox"/> WCB Injury |
| <input type="checkbox"/> Compassionate Care Program | <input type="checkbox"/> MVA Injury | <input type="checkbox"/> Custom Orthotics | |
| <input type="checkbox"/> Complimentary 15 Minute Video Consultation | <input type="checkbox"/> Other (please explain): _____ | | |

Relevant History and Examination: (include any relevant investigations, imaging studies, consults)

REFERRING PHYSICIAN SIGNATURE:

Place clinic contact information sticker here

SIGN HERE

Please fax completed referral to 403-775-4212