

Dr. Galati

Dr. Topos

Dr. Dhotar

Patients Name: _____ Date: _____

Diagnosis: _____

Precautions (please specify) _____

Patient Type MVA

Extended Health

W.S.I.B.

Treatment / Program

Full Rehabilitation Program
(as appropriate, Physiotherapy, Chiropractic, Massage Therapy & Acupuncture)

Physiotherapy

Chiropractic

Massage Therapy

Acupuncture

Other (please specify)

Braces / Splints

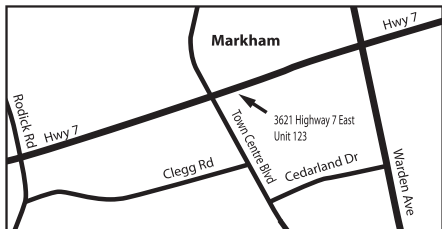
- Knee
- Ankle
- Wrist
- Lumbar
- Elbow
- Other (please specify)

T.E.N.S. Unit

In-Home / Worksite / Functional Assessment

Referring Physician: Dr. _____

Telephone: _____



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Warden / Hwy 7

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