Referral Date: ____________________________

Referral To: ____________________________

Referral Physician: ________________________

Billing Number: ___________________________

Reason for Referral: _______________________

Please include all recent imaging reports (XRAY, US, CT, MRI)

In the event this referral is not approved, we will contact your office. Please ensure your telephone/fax numbers are included on the referral.

**Body Part:**
- [ ] Foot / Ankle
- [ ] Lower Leg
- [ ] Knee / Patella
- [ ] Hip
- [ ] Back
- [ ] Shoulder
- [ ] Elbow
- [ ] Wrist / Hand
- [ ] Head

**Type of Injury:**
- [ ] Sprain
- [ ] Separation
- [ ] Ligament Tear
- [ ] Meniscal Injury
- [ ] Tendinopathy
- [ ] Avulsion Fracture
- [ ] Stress Fracture
- [ ] Dislocation
- [ ] Concussion
- [ ] Other

**Sport Played:** ___________________________

**Investigations:** _________________________

**Treatment Initiated:** _____________________

**Contact Info**
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