# HaleyRehab REFERRAL

*Dedicated to keeping you doing what you love!*

## Fax to 613-422-5186

| PATIENT NAME | HOSPITAL ID# | TELEPHONE No. | DATE OF BIRTH |
|---|---|---|---|
| | | | |

**CANCER DIAGNOSIS AND TREATMENT**

**PRECAUTIONS**

**REASON FOR REFERRAL**

**PHYSIOTHERAPY** ☐ **MASSAGE THERAPY** ☐

**COMMENTS**

**PHYSICIAN'S NAME (please print)** **PHYSICIAN'S SIGNATURE** **DATE**

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