

MyoA for YOUth REFERRAL FORM

Please complete all sections of this form and fax it to **236-471-6962**.

Please ensure to verify all **inclusion** and **exclusion** criteria below.



#103 - 4088 Cambie Street
Vancouver, BC, V5Z 2X8

TEL / FAX: **(236) 471-6962**

E-mail: myoAforYOUth@gmail.com

Website: www.myoaforyouth.com

INCLUSION CRITERIA

- Patient age is 17-35.
- Presumed myofascial dysfunction causing mobility impairment and/or pain.
- Other remedial cause for pain has been excluded.
- No needle aversion.
- Not currently pregnant.
- Not immunocompromised.
- Patient has a Primary Care Provider.

EXCLUSION CRITERIA

- Patients with active WorkSafe BC / ICBC claims.
- Patients with mental health conditions that are not currently well controlled.
- Pregnant patients.
- Patients with language barriers where interpretation support is not available.
- Patients who are wheelchair bound.

Referral Date:

PATIENT INFORMATION

First Name:		Last Name:		DOB:	
PHN:		Gender:		Pronouns:	
Address:		City:		Postal:	
Primary#:		Other#:		E-Mail:	
Parent/Guardian (if under 18):		Parent's Contacts:			

PHYSICIAN INFORMATION

Referring Provider:		Billing#:		Specialty:	
Address:		City:		Postal:	
Phone#:		Fax#:		Office E-mail:	
Primary Care Provider:		Billing#:		Specialty:	
Address:		City:		Postal:	
Phone#:		Fax#:		Office E-mail:	

PAIN SITE AND DURATION

Site(s):		Duration:	
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REASON FOR REFERRAL & RELEVANT MEDICAL HISTORY (Please include all current MEDICATIONS)

Has a remedial cause for pain been excluded?	
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OTHER SPECIALISTS / SERVICES CONSULTED (Check all that apply)

SERVICE	DATE OF EXAM	PLEASE ATTACH CONSULT LETTER WITH THIS REFERRAL
☐		
☐		
☐		
☐		
☐		

INVESTIGATIONS PERFORMED (Check all that apply)

INVESTIGATION	DATE OF EXAM	PLEASE ATTACH RESULTS WITH THIS REFERRAL
☐ X-RAY		
☐ MRI		
☐ Bone Scan		
☐ Bloodwork		

SUBMIT