

# 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.

### 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.

130 14th Street E  
North Vancouver, BC, V7L 2N3

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

E-mail: [myoAforYOUth@gmail.com](mailto:myoAforYOUth@gmail.com)

Website: [www.myoaforyouth.com](http://www.myoaforyouth.com)

**Referral Date:** \_\_\_\_\_

## PATIENT INFORMATION

Full Name:  Preferred:  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:

## REASON FOR REFERRAL & RELEVANT MEDICAL HISTORY (Please include all current MEDICATIONS)

Has a remedial cause for pain been excluded?

## 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
<input type="checkbox"/> X-RAY		
<input type="checkbox"/> MRI		
<input type="checkbox"/> Bone Scan		
<input type="checkbox"/> Bloodwork		