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 17-25.
- 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
Website: 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

Multisite | **Site(s):** | **Duration:** >3 years

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

Has a remedial cause for pain been excluded? No

OTHER SPECIALISTS / SERVICES CONSULTED (Check all that apply)

SERVICE	NAME OF PRACTITIONER	SERVICE	NAME OF PRACTITIONER
☐ Endocrinology		☐ Physiotherapy	
☐ Gastroenterology		☐ Psychiatry	
☐ Neurology		☐ Psychology	
☐ Orthopedics		☐ Rheumatology	
☐ General Surgery		☐ Other	

INVESTIGATIONS PERFORMED (Check all that apply)

INVESTIGATION	DATE OF EXAM	Other Investigations	DATE OF EXAM
☐ X-RAY		☐	
☐ MRI		☐	
☐ Bone Scan		☐	
☐ Bloodwork		☐	

SUBMIT