Naturally Balanced
~ Therapy ~

Referral Form

Referring Provider:

Clinic: _____
Name: _____
Phone: _____
Fax: _____

Patient Information:

Name: _____
Phone: _____
DOB (Y/M/D): _____

Referral For:

- ☐ Perinatal Complex Injury (DC)
- ☐ Pelvic Health (PT)
- ☐ Hypermobility/EDS (PT)
- ☐ Breastfeeding & Infant (PT)
- ☐ Chronic Pain (PT)
- ☐ General Physiotherapy
- ☐ General Chiropractic

Desired Outcomes:

- ☐ Consult/Second Opinion
- ☐ Assess and Treat
- ☐ Report of Findings
- ☐ Other: _____

PT- physiotherapist
DC- chiropractor

Note:

Return Form via
Fax: 403-277-2335
Email: NaturallyBalancedTherapy@shaw.ca
*or direct patient to bring to their appointment

Questions? Call: 403-277-2330

4813 Centre ST NW Calgary AB T2E 2Z6
NaturallyBalancedTherapy.ca