## REQUEST FOR CONSULTATION WITH DR. KATHRYN WILKINS FOR AMPUTEE CLINIC



PATIENT NAME:	_
ADDRESS:	_
TELEPHONE #  HEALTH CARD #	
REASON FOR AMPUTATION (DIAGNOSIS):	
LEVEL OF AMPUTATION: BELOW KNEE ABO BELOW ELBOW	
SIDE OF AMPUTATION: LEFT RIGHT	DATE OF AMPUTATION: MM DD
RELEVANT MEDICAL HISTORY:	
CURRENT PRESCRIBED MEDICATIONS:	
REFERRING PHYSICIAN:  PLEASE PRINT CLEARLY	OHIP BILLING #
SIGNATURE	DATE

ALL REFERRALS MUST BE FAXED TO: 705-725-7313

THIS FORM MUST HAVE **ALL** INFORMATION COMPLETED.