Sport Med North Dr. James Carson

255 Main St. Unionville, Ont. L3R 2H3 P. 9054770027 F. 9054770065

Patient Intake Form

Please read our new appointment policies:

Dr. James Carson will see physician consults, therapist referrals and self-referrals. We encourage referrals to be acute sport, recreation or dance injuries, including medical issues related to sport / exercise, with a priority to injuries or issues that are less than 6 months in duration. We discourage referrals that are concussions (as we can no longer see you on a timely basis), MVA (motor vehicle accident), WSIB or legal concern patients and patients who have been injured for more than 6 months. Physician's office referrals will need to include the equivalent information as our Intake Form (see below) or an Intake Form in addition, before giving an appointment time. Otherwise if you wish to see Dr. Carson for a sport medicine, dance medicine or concussion concern, please note that all patients **MUST COMPLETE OUR INTAKE FORM**. Even if you have been to our office in the past, all new assessments require you to send us a completed Intake Form. If you require a follow-up visit for a recent (within 3 months) assessment, the Intake Form is *not* necessary. Please note that even if you complete this form, we may be unable to offer you an appointment. We will do our best to inform you by phone or email regarding the status of your request within a few business days. Please view our internet privacy policy ("contact" link) on mydoctor.ca/drjamescarson Please note: **sport medicine patients should expect to be to be seen by medical students/residents as well as by Dr. Carson. Please bring shorts / T-shirt / tank top to our office.**

*** Indicates mandatory answers** Please print clearly in **black** ink.

***TODAY'S DATE:**		
***YOUR NAME:**		
***YOUR FULL ADDRESS:**		
***DATE OF BIRTH: YEAR:**	**MONTH:**	**DAY:**
***YOUR EMAIL ADDRESS:**		
***YOUR PHONE NUMBERS (DAYTIME / EVENING)**		
***OHIP NUMBER:**	***VERSION CODE (2 LETTERS):**	

***REASON FOR OFFICE VISIT (PLEASE CHECK ☑) :**

RECREATION INJURY ☐	SPORTS INJURY ☐	DANCE INJURY ☐	CONCUSSION ☐

***HOW MANY DAYS / WEEKS/ MONTHS HAVE YOU HAD THIS CONCERN?:**
***WHAT BODY PART IS INJURED?**
HAVE YOU HAD A SIMILAR INJURY BEFORE:
HAVE YOU HAD IMAGING? (XRAY, MRI, ULTRASOUND, SCAN) YES/NO:
IF YES, WHAT TYPE OF IMAGING WAS IT?
HOW DID YOU LEARN ABOUT SPORT MED NORTH?
***IS THIS A WSIB / LEGAL OR MVA (ACCIDENT) CONCERN?**
HAVE YOU HAD THIS CONCERN ASSESSED BY ANOTHER DOCTOR? YES/NO
IF YES…BY WHOM?
REFERRING DOCTOR OR THERAPIST'S NAME & OFFICE FAX NUMBER:
YOUR FAMILY DOCTOR'S NAME:
AFTER YOU COMPLETE THIS FORM FAX IT TO: 9054770065 ***OR* EMAIL:** drjamescarson@gmail.com

FOR DOCTORS' OFFICES ONLY:
YOUR 6 DIGIT OHIP NUMBER = YOUR OFFICE FAX # =

Version 12/2018

- THANK YOU FOR YOUR COOPERATION -