neuromotion
PHYSIOTHERAPY + REHABILITATION

VICTORIA
100 - 775 Topaz Avenue, Victoria, BC V8T 4Z7
T 250-590-7878 | F 250-590-8700
victoria@neuromotionphysio.com

Referral

Neurological Pelvic Floor Physiotherapy

Patient's Name: ______________________

Telephone ______________________

Date of Birth ______________________

Personal Health Number ______________________

Referring Physician: ______________________

Telephone ______________________

Fax ______________________

Email ______________________

Other Physicians involved

Gynaecologist ______________________

Urologist ______________________

Neurologist ______________________

Pelvic Health Concerns	Yes	No
Urinary Incontinence		
Pelvic Organ Prolapse		
Urinary Retention		
Fecal Incontinence		
Vulvodynia/Vaginismus		
Coccydynia		
Prostate Cancer		
Constipation		
Dyspareunia/Painful intercourse		
Pelvic Pain		
Nocturia		

Medical History:	
Surgical History:	
Medications (including OAB meds and Estrogen therapy):	
Has the patient had Urodynamics:	Yes ☐ No ☐ If yes, please include report.

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Physician's signature