CArE Osteoporosis Workshop
Patient Osteoporosis Self-Referral Form

Date of Referral: _____

PATIENT INFORMATION

First Name: _____

Last Name: _____

Address: _____

Date of Birth: _____

OHIP Number: _____

Phone number: _____

Email: _____

☐ **Diagnosed with OP?**

☐ **Applying on behalf of a family member?**

☐ **Are you planning to attend with a companion?**

PRIMARY CARE PROVIDER

Name: _____

Phone: _____

Fax: _____

Email: _____

Please email completed form to learn@carearthritisteam.ca

Media consent

I, _____, give permission to the Centre for Arthritis Excellence (CArE) to take and use photographs, videos, or digital images of me for educational purposes, including printed materials, presentations, and websites. I understand that my name will not be used with these images. I agree that CArE may use the images indefinitely and without payment to me.

Signature: _____ **Date:** _____

Note:
Self-referral does not guarantee workshop registration. Registration is subject to space availability. Clinicians will not complete a formal intake for these patients. Following the workshop a letter/notice of attendance will be sent to the primary care provider.