Scarborough Health Network (SHN)
Orthopaedics Referral Form

Date: _____

Please Note:
This listing is for **urgent referrals only**, and not accepting routine referrals at this time. If your patient needs attention in 24-48 hours, ***please direct them to the nearest Emergency Department***.
Your patient's appointment will be booked at the SHN site most appropriate for their care. The specific appointment location will be communicated directly to your patient at time of booking.
We **do not see patients with hand fractures**, please send these referrals directly to the SHN Plastics Clinic.
You can send elective referrals directly to providers - for more information on the SHN Orthopaedic providers and their subspecialties, please view the Ortho Scorecard.

Patient Information	Referring Physician Information
Surname: First name: DOB: Gender: ☐ Female ☐ Male ☐ Other: _____ Health card #: VC: Address: Contact number: Email: Best method of contact: Health Coverage: ☐ OHIP ☐ Self-Pay ☐ IFH (Refugee) ☐ 3rd Party ☐ WSIB – WSIB Claim Number:	Name: Address: Billing #: Telephone: FAX: Email: Are you a Scarborough SCOPE-registered Primary Care Provider? ☐ Yes ☐ No Click here to learn more about SCOPE

Reason for Referral

Name of Suspected Diagnosis/Problem Triggering Referral, Duration of Symptoms, Hand Dominance (if relevant) and any other Relevant History (*i.e. right-hand dominance; right distal radius fracture from FOOSH injury 5 days ago*):

_____

_____

_____

_____

Brief Description of Investigations and Management:

_____

_____

_____

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Diagnostic Imaging Requirements (recent imaging is required for referrals**)

☐ X-ray
☐ Ultrasound
☐ CT
☐ MRI/MRArthrogram

Previous Treatments:

☐ Analgesics
☐ Physiotherapy
☐ Cortisone injection
☐ Surgery
☐ Other
☐ None

Please attach an up-to-date Cumulative Patient Profile and imaging reports with all referrals.