Scarborough Health Network (SHN)
Orthopaedics Referral Form

Date: _____

Patient Information	Referring Physician Information
Surname: First name: DOB: Gender: ☐ Female ☐ Male ☐ Other Health card #: VC: Address: Contact number: Email: Best method of contact: Height (cm): Weight (kgs): Translator required (if applicable): Is this a Pediatric patient (<18 years of age): ☐ Yes ☐ No Health Coverage: ☐ OHIP ☐ Self-Pay ☐ IFH (Refugee) ☐ 3rd Party ☐ WSIB – WSIB Claim Number:	Name: Address: Billing #: Telephone: FAX: Email: Are you are Scarborough SCOPE registered Primary Care Provider? ☐ Yes ☐ No

Reason for Referral

Please note: We are not accepting routine referrals at this time. All urgent referrals are triaged by the Orthopaedic Navigator and will be allocated to the appropriate SHN provider based on urgency and subspecialty.

Urgency: ☐ Urgent (5-7 days) ☐ Emergency (send patient to ED)

Duration of Symptoms: ☐ Acute onset ☐ <6 months ☐ 6-12 months ☐ >12 months ☐ Other

Name of Suspected Diagnosis/Problem Triggering Referral and any Relevant History:

_____

_____

_____

Primary problem/area (*joint and laterality*): _____

Traumatic Onset: ☐ Yes ☐ No

Prior/Recurrent History: ☐ Yes ☐ No

Paresthesia/Numbness: ☐ Yes ☐ No

Progressive pain & disability: ☐ Yes ☐ No

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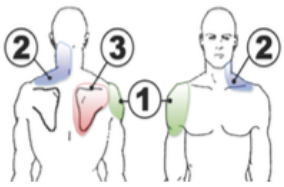
If shoulder (fill below):

Location of pain:



☐ None
☐ 1 (lateral)
☐ 2 (neck/trapezius)
☐ 3 (scapula)

Hand Dominance: ☐ Right ☐ Left

Traumatic onset: ☐ Yes ☐ No

Unable to raise arm away from body within 24 hours of the injury: ☐ Yes ☐ No

Fracture/Dislocation: ☐ Yes ☐ No

Hx of Multiple Dislocations: ☐ Yes ☐ No

Prior/recurrent history: ☐ Yes ☐ No

Hx of gradual worsening pain & progressive loss of shoulder ROM: ☐ Yes ☐ No

If spine (fill below):

Reason for Referral:

☐ Tumour
☐ Infection
☐ Fracture
☐ Degenerative Cervical Myelopathy
☐ Degenerative Cervical Radiculopathy
☐ Degenerative Lumbar Stenosis

Symptoms (*select all that apply*)

☐ Neck pain
☐ Radicular arm pain/numbness
☐ Hand numbness/weakness/clumsiness
☐ Balance difficulties
☐ Back pain
☐ Sciatica/radicular leg pain
☐ Claudicant leg pain

Brief Description of Investigations and Management:

_____

_____

_____

Diagnostic Imaging Requirements (within the last 6 months to 1 year. If urgent, then recent imaging) – *please attach and select to confirm attachments below.*

☐ 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.