Physician Referral Form

Consultation for Orthopaedic Concerns

Fax: 250-374-0357

http://kamloopsortho.ca/

URGENT REFERRALS: Referrals regarding acute fracture, infection, or tumour, please discuss with Orthopaedic Surgeon on call (RIH 250-374-5111).

Date of Referral:

Patient Information (AFFIX LABEL OR COMPLETE)		**SEND RESULTS TO:**
NAME First:	Surname:	Referring Practitioner:
DOB:	AGE: M: ☐ F: ☐	MSP # Locum:
PHN:		Clinic name Street address (affix label or complete) Phone Fax
E-MAIL:		
PHONE #:	CELL PH:	
ADDRESS:		Primary care provider: ___Same as referring practitioner ___ Copy to (Full name)________________
City:	Prov: Postal Code:	

Upon review, receipt of referral will be confirmed via fax to referring physician's office where the approximate wait time for the appointment will be indicated. Patients will be contacted directly to schedule their appointment closer to when consultation times become available.

Additional Patient Information:	**Is Condition Work Related?** ☐ Yes* ☐ No
Height: __________Weight: __________	WSBC Claim #: ___________ Date of Injury:__________
BMI: ________	*** If yes, please attach WSBC approval for expedited referral**

Refer To: ☐ **First Available Appropriate Surgeon**

☐ **Requested Dr: ______________________________**

Reason for Referral: (Please tick one in each section)

Hip	Shoulder	Other:	Left	N/A	Arthritis
Knee	Elbow		Right		Non-Arthritis
Foot/Ankle	Hand/Wrist		Bilateral		

History of Complaint: **Letter attached** ☐

Severity of Symptoms:	**Duration of Symptoms:**
Mild Moderate Severe Sleep Disturbing	Acute 3-6 Months 6-12 Months >12 Months

Treatment Hx: ☐ Physiotherapy ☐ Modified Exercises ☐ Injections (specify): ________________________

☐ Analgesics ☐ NSAIDs ☐ Other (specify): ________________________

Pertinent Medical History: **OR / Consult Reports** **Attached** ☐

Current Medications: **List Attached** ☐

Allergies: **List Attached** ☐

X-Rays of the affected area are MANDATORY for Patient Triage (completed within 1 year of referral date)

Note - X-rays are not required for carpal tunnel syndrome, trigger digit, or Dupuytren's disease. NCS/EMG are required prior to referral for carpal tunnel syndrome or other peripheral compression neuropathy.

Please see website http://kamloopsortho.ca/radiology for details regarding the views obtained within each series, and attach the completed imagining report

Please specify **acute/trauma** or **chronic/degenerative** when ordering the following x-rays: shoulder, elbow, wrist +/- scaphoid, hand, hip, knee, ankle, and foot i.e. "acute shoulder series" or "chronic knee series"

MRI or CT scan CANNOT be used in place of X-Rays. Imaging reports must be attached for referral to be accepted.