COWICHAN VALLEY ORTHOPAEDICS REFERRAL FORM

FAX: 778.568.0865

URGENT REFERRALS: *CONTACT ON-CALL ORTHO FOR REFERRALS REGARDING ACUTE FRACTURE, INJURY, INFECTION, OR TUMOUR*

DATE OF REFERRAL: (DD/MM/YYYY)

IF APPLICABLE: WORKSAFE BC #: _____
DATE OF INJURY: _____ (DD/MM/YYYY)

PATIENT INFORMATION: (AFFIX LABEL OR COMPLETE)

LAST NAME:
FIRST/ MIDDLE: /
PHN:
PHONE #:
E-MAIL:
ADDRESS:

DOB: (DD/MM/YYYY)
AGE:
HEIGHT:
WEIGHT:
BMI:

REFERRING PHYSICIAN/PRACTITIONER: (AFFIX LABEL OR COMPLETE)

NAME: MSP #:
PHONE: FAX:
CLINIC NAME: (IF APPLICABLE)
ADDRESS:

FAMILY DOCTOR/PRACTITIONER: (IF DIFFERENT FROM REFERRING PHYSICIAN)

BODY PART:

- ☐ SHOULDER
- ☐ ARM
- ☐ ELBOW
- ☐ FOREARM
- ☐ HAND/WRIST
- ☐ PELVIS
- ☐ HIP
- ☐ KNEE
- ☐ LEG
- ☐ ANKLE
- ☐ FOOT
- ☐ NERVE
- ☐ OTHER: _____

EXPEDITED APPOINTMENT:

☐ FIRST AVAILABLE*

SPECIFIC PHYSICIAN REQUESTED**:

_____

** PATIENT WILL SEE A SCREENING PHYSICIAN FIRST OR BE DIRECTED TO THE MOST APPROPRIATE PHYSICIAN FOR CONSULTATION*

*** PATIENT MAY BE REDIRECTED TO THE MOST APPROPRIATE SPECIALIST AT THE DISCRETION OF COWICHAN VALLEY ORTHOPAEDICS*

DIAGNOSIS:

- ☐ ARTHRITIS
- ☐ FRACTURE
- ☐ SOFT TISSUE INJURY
- ☐ LIGAMENT INJURY
- ☐ TENDON INJURY
- ☐ INTERNAL DERANGEMENT
- ☐ OTHER: _____

SYMPTOMS DURATION: _____ (# WEEKS)

LATERALITY: ☐ LEFT ☐ RIGHT ☐ BILATERAL

SEVERITY ☐ MILD ☐ MODERATE ☐ SEVERE

REASON FOR REFERRAL: (INCLUDE DIAGNOSIS & TREATMENTS TO DATE) ☐ LETTER ATTACHED

PAST MEDICAL AND SURGICAL HISTORY: ☐ ATTACHED

MEDICATION LIST: ☐ ATTACHED

ALLERGIES:

X-RAYS OF THE AFFECTED AREA ARE MANDATORY FOR TRIAGE OF PATIENT

X-RAYS SHOULD BE COMPLETED WITHIN 6 MONTHS OF REFERRAL DATE OR AFTER AN ACUTE INJURY

MRI CANNOT BE USED IN PLACE OF X-RAYS

☐ X-RAY ATTACHED

BODY PART	SUGGESTED X-RAY VIEWS	BODY PART	SUGGESTED X-RAY VIEWS
ACUTE SHOULDER	TRUE AP/TRANSSCAPULAR Y/AXILLARY	HIP	WEIGHT BEARING AP PELVIS AND LATERAL OF AFFECTED SIDE
CHRONIC SHOULDER	AP IN NEUTRAL/AP IN IR/TRANSCAP Y/AXILLARY/ZANCA	CHRONIC KNEE	WEIGHT BEARING BILATERAL AP /LATERAL/NOTCH/SKYLINE
ELBOW	AP/LATERAL/OBLIQUE	ACUTE KNEE	AP/LATERAL/NOTCH/SKYLINE
WRIST	PA/LATERAL (OPTIONAL: SCAPHOID VIEW)	ANKLE	AP/LATERAL/MORTISE
HAND	AP/LAT/OBLIQUE	FOOT	BILATERAL WEIGHT BEARING AP/LATERAL/OBLIQUE