***NOTE: Incomplete and / or unsigned requistions will be returned***

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Markham Stouffville Hospital
Oak Valley Health

Hospital MRN #: _____

Patient Name: _____
Last First

Date of Birth: _____ Sex: F M
Day Month Year

Health Card # _____ Version Code: _____

☐ WSIB # _____ ☐ Non OHIP (Self-pay) or Refugee

Address: _____ Postal Code: _____

Tel # (Best Daytime): _____ Alternate #: _____

Email: _____

# Request for Orthopaedic Consultation
# Shoulder, Ankle and Foot Management

**Please Fax To: 1-855-346-9138**

| **Date** | **Referring MD** | **Signature** | |
|---|---|---|---|
| **CPSO #** | **Billing #** | **Telephone** | **Fax** |
| **Address** | | | **Email Address** |
| **Family Physician (if different)** | **Address** | | **Telephone** |
| Preferred Language | Name & number of interpreter to help schedule appointment, if available<br>**Please bring an interpreter to the appointment if required.** | | |

## Consultation Options: ☐ Shoulder ☐ Ankle/Foot

☐ **Oak Valley Health - Markham Stouffville Hospital**

☐ Preferred Surgeon, Dr._____ OR ☐ First Available Surgeon

## Clinical Information

**Treatment to date:** ☐ Analgesics ☐ NSAID ☐ Injections ☐ Physiotherapy ☐ Exercise ☐ Surgery

Other treatments:_____

**Shoulder:** ☐ Right ☐ Left

- ☐ Rotator cuff disorder or tear
- ☐ Inflammatory arthritis
- ☐ Osteoarthritis
- ☐ Instability/labral tear
- ☐ Acromioclavicular joint
- ☐ Impingement syndrome
- ☐ Adhesive capsulitis

**Ankle:** ☐ Right ☐ Left

- ☐ Osteoarthritis
- ☐ Instability OCD
- ☐ Avascular necrosis
- ☐ Tendinopathies/tendon tears
- ☐ Instability/ligament tears
- ☐ Hardware complications
- ☐ Cysts/ganglion/growths

**Foot:** ☐ Right ☐ Left

- ☐ Osteoarthritis
- ☐ Toe deformities
- ☐ Bunion
- ☐ Avascular necrosis
- ☐ Charcot
- ☐ Cysts/ganglion/growths
- ☐ Tendinopathies/tendon tears
- ☐ Pes planus/cavus
- ☐ Hardware complications

**IMAGING REPORTS OF THE EFFECTED JOINT MUST ACCOMPANY REFERRAL**

If no imaging report is available from within the last 6 months, we recommend the following:

**Shoulder:**
- ☐ AP, lateral and axillary
- ☐ U/S or MRI as appropriate

**Ankle:**
- ☐ Weight-bearing AP
- ☐ Weight-bearing lateral
- ☐ Weight-bearing Mortise

**Foot:**
- ☐ Weight-bearing AP
- ☐ Weight-bearing medial oblique
- ☐ Weight-bearing lateral

* Soft tissue ankle/foot disorders require ultrasound or MRI

** Note: Please ensure all sections of this referral are fully completed. If disc is available with imaging, please bring to appointment. Referrals that do not have accompanying imaging will not be accepted. This referral is not to be used for urgent cases e.g. fractures, tendon ruptures **