

Shoulder - Orthopaedic Consultation Request Central Intake

FAX: 1-855-346-9138

Referral Date:	YYYY	MM	DD
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MSK Central Region - Central Intake

Preferred Surgeon, Dr. _____ or First Available Surgeon

Referring Physician Information

Name: _____

Address: _____

Phone: _____

Fax: _____

Billing #: _____

Signature: _____

Family Physician Information (if different)

Name: _____

Phone: _____

Patient Information

Name: _____

Address: _____

Date of Birth: _____

Health Card #: _____ VC: _____

Gender: Male Female

Language if unable to speak

English: _____

Phone: _____

Alternate Phone: _____

Clinical Information

Etiology: Non-traumatic Traumatic Overuse WSIB MVC

Treatment to date: Analgesics NSAID Injections Exercise Physiotherapy Surgery

Other treatments: _____

Shoulder: Right Left

Rotator cuff disorder or tear

Inflammatory arthritis

Osteoarthritis

Instability/ labral tear

Acromioclavicular joint

Impingement syndrome

Frozen shoulder

Other

IMAGING REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL

If x-ray and ultrasound report is available from within the last 3 months, we highly recommend the following:

Shoulder:

X-ray: AP shoulder, lateral

U/S

Please ensure that imaging reports are included in the referral. Patients should bring either DVD or access codes to allow viewing of X-rays, or MRI (if available)

**** Note:** Please ensure all sections of this referral are fully completed. 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 **