NOTE: Incomplete and / or unsigned requistions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

MARKHAM STOUFFVILLE HOSPITAL CORPORATION

Request for Orthopaedic Consultation
Shoulder, Ankle and Foot Management

Please Fax To: 1-855-346-9138

Hospital MRN #: _____

Patient Name: _____
Last First

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

Health Card # _____ Version Code: _____

Address: _____ Postal Code: _____

Telephone # (Best Daytime): _____

Alternate #: _____

Email: _____

Date	**Referring MD**	**Signature**
Billing #	**Address**	

Fax	**Telephone**	**Email Address**
Family Physician (if different)	**Address**	**Telephone**
Patient Spoken Language if other than English	Contact Information for Translator if Required (Name & Number) **Please bring a translator to the appointment if required.**	

Diagnosis:

Shoulder: ☐ R ☐ L
Ankle: ☐ R ☐ L
Foot: ☐ R ☐ L

☐ Osteoarthritis ☐ Inflammatory Arthritis ☐ Post-Traumatic Arthritis ☐ Trauma

☐ Other: _____

Reason for Referral:

Opinion/Management Advice: ☐ Shoulder ☐ Ankle ☐ Foot

Primary Replacement: ☐ Shoulder ☐ Ankle ☐ Foot

Treatments to date:

☐ Analgesics ☐ Physiotherapy ☐ Injections ☐ Non-steroid ☐ Exercise ☐ Viscosupplement

☐ Other: _____

Patient will bring a CD (within the last 6 months) of their x-ray to appointment (required)

X-ray or MRI reports of the affected joint must accompany referral
If no X-ray report is available from within the last 6 months, we recommend the following views:

Shoulder: AP, lateral and axillary

Ankle/Foot: Standing bilateral feet/ankle x-rays if available. Talus osteochondral lesion MRI.
Any ankle ligament requires a MRI. Ankle and subtalar/midfoot OA requires a CT.
Big toe arthritis requires an X-ray.

*** * * Note: Current Imaging - Please provide all imaging and imaging reports of affected joint with the referral to OJAC. If a disc is available, please send ahead of time or with patient.**