NOTE: Incomplete and / or unsigned requistions will be returned

Markham Stouffville Hospital
Oak Valley Health

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION

Hospital MRN #: ______________________

Patient Name: ______________________ (Last / First)

Date of Birth: ______________________ (Day / Month / Year) Sex: F M

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 **Please bring an interpreter to the appointment if required.**		

Consultation Options: ☐ Shoulder ☐ Ankle/Foot

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

Clinical Information

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

Other treatments:______________________

Shoulder: ☐ Right ☐ Left

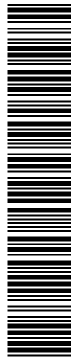
- ☐ Rotator cuff disorder or tear
- ☐ Inflammatory arthritis
- ☐ Osteoarthritis
- ☐ Instability/labral tear
- ☐ Acromioclavicular joint
- ☐ Impingement syndrome
- ☐ Adhesive capsulitis

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
- ☐ Plantar fasciitis
- ☐ 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:

- ☐ X-ray: 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 **