

NOTE: Incomplete and / or unsigned requisitions will be returned

PLEASE PRINT CLEARLY
OR AFFIX LABEL WITH COMPLETE INFORMATION



**Markham
Stouffville
Hospital**
Oak Valley Health

Request for Orthopaedic Consultation Shoulder, Ankle and Foot Management

Please Fax To: 1-855-346-9138

Hospital MRN #: _____

Patient Name: _____

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

Health Card # _____ Version Code: _____

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

Address: _____ Postal Code: _____

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

Email: _____

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.		

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.**

