Sunnybrook
HOLLAND ORTHOPAEDIC & ARTHRITIC CENTRE

Shoulder Program

REQUEST FOR CONSULTATION

PLEASE **FAX** COMPLETED FORM AND ADDITIONAL INFORMATION TO **(416) 599-4577**

Date:	YY	MM	DD

Physician Information

Referring Physician Information

Name: ______________________________

Specialty: ______________________________

Address: ______________________________

____

____

Phone: ______________________________

Fax: ______________________________

Email: ______________________________

Billing #: ______________________________

Signature: ______________________________

Family Physician Information (if different)

Name: ______________________________

Phone: ______________________________

Patient Information

Name: ______________________________

Address: ______________________________

____

____

Date of Birth: ______________________________

Health Card #: ____________________ VC: _____

Gender: ☐ Male ☐ Female

Phone (Home): ______________________________

Phone (Work): ______________________________

Phone (Cell): ______________________________

Email: ______________________________

Is patient covered by WSIB?
☐ Yes, #:_________________; ☐ No

Clinical Information

DIAGNOSIS/REASON FOR CONSULT:

☐ Impingement syndrome / Partial-thickness rotator cuff tear / Acromio-clavicular joint arthritis
☐ Full-thickness rotator cuff tear – **please attach Ultrasound, MRI reports**
☐ Arthritis
☐ Frozen Shoulder
☐ Instability
☐ Failed Surgery – **please attach operative reports, X-Ray reports, reports of other investigations**

☐ Other: ____

URGENCY: ☐ Routine ☐ Urgent

TREATMENTS TO DATE (check all that apply)

☐ Physiotherapy ☐ Analgesics ☐ Non-steroidal anti-inflammatory drugs ☐ Injections
☐ Arthroscopy ☐ Total Shoulder Replacement
Other: ____

Has there been a recent significant change in function, pain level and/or range of motion?
Are there systemic signs (e.g., fever, chills)? Other significant issues?

____

Please forward any additional information that will assist us in determining urgency

TC Ref. ID# : MRN#:

CI USE ONLY

Triage Code: ☐ A ☐ B ☐ C ☐ D Triaged by: _________________ Date (YY/MM/DD):_________________

Please note that **all areas ABOVE the double line MUST be completed**