Sunnybrook
HOLLAND ORTHOPAEDIC & ARTHRITIC CENTRE

Shoulder Program
Request for Consultation

PATIENT IDENTIFICATION

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

Date: YYYY 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: YYYY / MM / DD
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 and 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

CI USE ONLY

Toronto Central LHIN Ref. ID# : MRN#: Triage Code: ☐ A ☐ B ☐ C ☐ D

Triaged by: _____ _____ _____
Signature **PRINT NAME & Credentials** **Date (YYYY/MM/DD)**

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

PR14164

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(2010/05/10)