Pacific Orthopaedics And Sports Medicine

Comprehensive and Integrated Musculoskeletal Care

PATIENT REFERRAL FORM

FAX 604-914-2521

DATE OF REFERRAL	**REFERRING PHYSICIAN**	Name:	MSP No.
		Family Physician (if different):	

PATIENT INFORMATION (*or affix label*)

Last Name:	Gender:
First Name:	Email:
DOB:	Phone 1:
PHN:	Phone 2:
WSBC Claim No.	City:

BODY REGION ***Spine** - refer to Neurosurgery* ***Hand/Carpus** - refer to Plastics*

☐ Shoulder / Arm	☐ Elbow / Forearm	☐ Wrist	**Laterality**
☐ Hip / Pelvis	☐ Knee / Leg	☐ Foot / Ankle	☐ Left ☐ Right

REASON FOR REFERRAL

☐ **Urgent Referral** for assessment **within 1-2 weeks**

**example - acute fracture, acute soft tissue injury, infection or tumour*

☐ **Non-Urgent Musculoskeletal Complaint**

☐ **Arthritis**

☐ **Injection (including ultrasound-guided)**

☐ **Bracing**

☐ **Follow-up Assessment. Who was the previous treating physician?** Dr. Jason Hui

☐ **Other** _____

RELEVANT HISTORY ***Please include HPI, PMHx/surgical Hx, and medications***

Documents attached ☐

Duration of Symptoms: _____ Severity of Symptoms: ☐ Mild ☐ Mod ☐ Severe

***MANDATORY* X-RAY REQUIREMENT**

X-ray report (within past 6 months) MUST accompany referral. Please see the Referral Checklist and Guide on PathwaysBC for recommended x-ray views.

Additional Imaging: ☐ Ultrasound ☐ CT ☐ MRI ☐ Nuclear Med

REQUESTED CONSULTANT

☐ First Available Appropriate Physician ☐ Specific Physician Name: Dr. Jason Hui