Vernon Orthopaedic Surgeons

Fax: 778-506-2060 www.vernonortho.ca

PATIENT INFORMATION:	**REFERRING PHYSICIAN:**
Name:	Name:
Email: (mandatory)	MSP:
Cell Phone:	Address:
PHN:	Phone:
DOB: Gender:	Fax:
Address:	If applicable, Walk in Clinic Name:
Home Phone:	
Secondary Contact:	**FAMILY PHYSICIAN:** (if not referring MD)
WCB Claim # _____D.O.I._____	

DATE:	**Patient to see next available physician?** **Yes** ☐ **No** ☐ **No. Prefer to see Dr. _____**

Duration of Symptoms: ☐<6 weeks ☐> 6 weeks **Severity of Symptoms:** ☐Mild ☐Moderate ☐Severe

Body Part: ☐Hip ☐ Knee ☐Foot/ Ankle ☐Shoulder/Elbow ☐Spine ☐Hand/Wrist ☐Other:

Laterality: ☐ Left ☐ Right

URGENT REFERRALS: Patients that require assessment within 14 days e.g. suspicion of tumor, infection or fracture are considered URGENT REFERRALS and should be discussed with the on call Orthopaedic Surgeon via the office or VJH Switchboard (250-558-1200).

REASON FOR REFERRAL: Include diagnosis & treatment to date. Letter Attached ☐

MEDICAL & SURGICAL HISTORY: History attached ☐	**MEDICATIONS:** List Attached ☐
	ALLERGIES: List Attached ☐

ADULT PATIENTS REQUIRE MEDICAL IMAGING FOR TRIAGE.

FOR SPINE REFERRALS, PLEASE REFER TO THE SPINE TRIAGE FORM

Have x-rays of affected area been obtained within the last 6 months?

☐ Yes, report attached

☐ No – Please be advised this referral CANNOT be triaged unless exceptional circumstances are indicated below:

Upon review, receipt of referral will be confirmed via fax to referring physician's office. An approximate wait for the appointment will be indicated. Patients will be contacted by surgeon's office to schedule appointment.