KOOTENAY ORTHOPAEDICS & SPORTS MEDICINE

Physician Referral Form
Fax: 250-368-8886

URGENT REFERRALS: PLEASE SPEAK TO ORTHO SURGEON ON CALL

Patient Information (affix label or complete):	**Referring Physician (affix label or complete):**
Name:	Name:
Date of Birth:	MSP:
PHN:	Clinic:
BMI:	Address:
Address:	Phone:
Primary Phone:	Fax:
Email Address:	
Date of Referral:	**WCB Claim #:** **Date of Injury:**
Surgeons: ❑ First available Ortho Surgeon ❑ Dr. Seth Bitting (Shoulder, Hip, & Knee) ❑ Dr. Michel Hjelkrem (Hip, Knee, Carpal Tunnel, Trigger Finger) ❑ Dr. Susan Ge (Foot & Ankle) ❑ Dr. Susan Ge (Wound Clinic) ❑ Dr. Kirsten Hickie (Hip & Knee)	**Attempted Treatment:** ❑ Physiotherapy ❑ Steroid/Viscosuplementation Injection ❑ Bracing/Orthotics ❑ Surgery ❑ Other

***X-RAYS WITHIN 6 MONTHS OF THE AFFECTED AREA ARE MANDATORY FOR TRIAGING**
***WEIGHT-BEARING X-RAYS ARE MANDATORY FOR ALL FOOT/ANKLE REFERRALS**
***ALL SHOULDER REFERRALS REQUIRE AN MRI OR US AS WELL AS X-RAYS**

Side: ❑ Left ❑ Right ❑ Bilateral

Body Part: ❑ Shoulder ❑ Elbow ❑ Hip ❑ Knee ❑ Foot/Ankle ❑ Carpal Tunnel/Trigger Finger ❑ Other: _____

Tentative Diagnosis:

Reason for Referral: Patient summary/past medical history must be provided or attached.

Duration of symptoms: _____ Severity of symptoms: ❑ Mild ❑ Moderate ❑ Severe