DR NICHOLAS CHANG
ORTHOPAEDIC SURGEON

REQUEST FOR ORTHOPAEDIC CONSULTATION

Please fax referrals to **905-237-8225**

Referral Date (YYYY/MM/DD):

Referring Physician Information

Name: _____
Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____
Billing #: _____
Signature: _____

Family Physician (if different)
Name: _____
Phone: _____
Fax: _____

Patient Information

Name: _____
Date of birth: _____
Sex: _____
Address: _____
_____
Health Card #: _____ VC: ____

Language: _____
(if unable to speak English)

Phone (Home): _____
Phone (Cell): _____
Phone (Work): _____
Email: _____
If WSIB, #: _____

Clinical Information

Diagnosis: (please select all that apply)**:**

SHOULDER	☐ Right	☐ Left
ELBOW	☐ Right	☐ Left
WRIST	☐ Right	☐ Left

☐ Rotator Cuff Full-Thickness Tear
☐ Rotator Cuff Partial-Thickness Tear / Impingement
☐ Osteoarthritis ☐ Inflammatory Arthritis
☐ Post-traumatic arthritis ☐ Instability / Labrum
☐ Frozen Shoulder ☐ Elbow Tendinopathy
☐ Elbow Stiffness ☐ Elbow Instability
☐ 1st CMC thumb arthritis ☐ DRUJ/TFCC tears
☐ Carpal/Cubital tunnel ☐ Trigger Finger
☐ Other _____

Treatments to date: (please select all that apply)**:**

☐ NSAIDs ☐ Physiotherapy ☐ Injection
☐ Splint ☐ Previous surgery ☐ _____

Urgency: ☐ Routine ☐ Urgent

Recent deterioration in symptoms/function/ROM?
☐ Yes ☐ No

Consideration for:
☐ Surgery ☐ Opinion Requested ☐ Injection

Past Medical History:

Current Medications:

Please attach the patient's imaging reports and any additional relevant clinical information. If the imaging was performed at an external clinic, please advise the patient to bring a CD with the images to their appointment.

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