Musculoskeletal Program – Shoulder Referral

Cornwall Community Hospital ▪ Hôpital Montfort ▪ Queensway Carleton Hospital
The Ottawa Hospital ▪ Pembroke Regional Hospital

Request For Consultation

Fax: 613-721-7889

REFERRAL DATE (YYYY/MM/DD):

***This referral is not to be used for urgent referrals (e.g. fractures, tendon ruptures, primary/acute dislocation of the shoulder)**

Referring Physician Information – may use stamp

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

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

Patient Information – may use sticker

Name: _____
Address: _____
_____
Phone: _____
Date of Birth: _____
Health Card #: _____
Gender: Male Female
Alternate Contact Information:
_____
_____
_____

Clinical Information

Diagnosis:

Right Left Bilateral

- ☐ Osteoarthritis
- ☐ Inflammatory Arthritis
- ☐ Labral Tear/ Instability/ Subluxation
- ☐ Rotator Cuff
- ☐ Rotator Cuff Tear – Acute/Traumatic
- ☐ Impingement Syndrome
- ☐ Other:

Specify: _____

Must attach minimum 1 diagnostic imaging report based on initial diagnosis:

- ☐ Xray: AP shoulder, lateral, true axillary
- ☐ Frozen shouler: distention arthrogram
- ☐ Labral tear/instability/subluxation: MRI arthrogram
- ☐ Rotator cuff tear: U/S or MRI

Treatment to Date

- ☐ None
- ☐ Physiotherapy
- ☐ Anti-Inflammatories
- ☐ Narcotics
- ☐ Massage
- ☐ Acupuncture
- ☐ Cortisone Injection(s)
- ☐ Other

Surgeon Preference:

- ☐ First Available Surgeon
- ☐ Specific Surgeon

_____