**Guidelines:**

1. Referring Physician to complete referral form.
2. Referral is to be faxed to the Rapid Access Clinic at 1-844-497-2445
3. The Rapid Access Clinic clerk will receive the referral form and route to the appropriate health care provider.
4. Completed referrals will be filed in the Rapid Access Clinic on the patient’s health record.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION** | | | | | | | | | | | |
| Last Name: | | First Name: | | |  | | | | | Gender  Male  Female | |
| Health Card Number: |  | | | | | Date of Birth: | Age:\_\_\_\_\_\_\_\_ | | | | |
|  |  | | | | |  | Day Month Year | | | | |
| Address: | | | City: |  | | | | Postal Code: | | |  |
| Phone Number: ( ) | | | | Alternate Phone Number: ( ) | | | | |  | | |

**Hand Dominance:**  Right  Left **Affected shoulder:**  Right  Left  Bilateral

**Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WSIB**  yes  no  **MVC**  yes  no

Where is the pain located?

Check all that apply or draw on diagram.

🞏 No Pain % of pain

🞏 1-Lateral Shoulder

🞏 2-Neck/Trapezius

🞏 3- Scapula \_\_\_\_\_\_\_ 

**Duration of symptoms or date of onset:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acute/Traumatic Injury:**  No  Yes

If yes,  fracture  dislocation  tendon rupture/tear

If dislocation, number of episodes\_\_\_\_ (#), required in hospital reduction\_\_\_ (#)

**Patient injury details/primary complaint**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is active and passive ROM equal and reduced?  yes  no Are they unable to lift arm away from their body?  yes  no

**\*Please attach patient profile, medication list and other pertinent information**

**Smoker**  yes  no **ETOH/other substances\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\*Recent shoulder X-rays including AP (anterior posterior), transcapular lateral and axillary lateral views are mandatory for triage. No other imaging is required but if other imaging has been done please include reports.**

**TREATMENT TO DATE FOR THIS PROBLEM**

|  |  |
| --- | --- |
| Physiotherapy  Anti-Inflammatory  Narcotics  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Steroid Injection Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Site  subacromial  glenohumeral  acromioclavicular  By whom\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Response none partial complete  Duration\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Previous assessment by surgeon?  No  Yes  If Yes, by whom? ­­­  Date\_\_\_\_\_\_\_\_\_\_\_\_ (DD/MM/YYYY)  Previous shoulder surgery?  Right  Left  Procedure:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(DD/MM/YYYY) |

**SURGEON/HOSPITAL OPTIONS**

First available surgeon  Preferred Surgeon\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Preferred Site\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Physician Name:Billing Number:

Address: Telephone: Fax: \_\_