Rebalance^{MD} Physician Referral Form

Rebalance MD

Orthopaedic Surgery - Physical and Rehabilitation Medicine - Sports Medicine

Phone 250 940 4444 Fax 250 385 9600

PATIENT INFORMATION: (affix label or complete)	**REFERRING PHYSICIAN:** (affix label or complete)
Name:	Name:
PHN:	MSP:
DOB: Gender:	Address:
Address:	Phone:
Home Phone:	Fax:
Alternate Phone:	If applicable, Walk in Clinic Name:
Email:	
Secondary Contact:	**FAMILY PHYSICIAN:** (if not referring MD)
WCB Claim # if applicable:	

DATE:	**Patient to see** "First Available Appropriate Specialist Triage (FAAST)"**?** ❒ Yes. ❒ No. Prefer to see Dr.:	**ACUTE MSK CLINIC?** ❒ Yes. **Date of Injury:**

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

Body Part: ❒ Hip ❒ Knee ❒ Foot/ Ankle ❒ Shoulder/Elbow/Wrist ❒ Other:

URGENT REFERRALS: Patients that require assessment within 30 days e.g. suspicion of *tumour, infection* or *fracture* are considered URGENT REFERRALS and should be discussed with the on call Orthopaedic surgeon via the office or VIHA Switchboard (250 370 8699)

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

Have x-rays of affected area been obtained?

❒ 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. Referring physicians will be advised by fax of appointment date once scheduled.

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