RebalanceMD Referral Form
Comprehensive Musculoskeletal Medicine
500-1665 W. Broadway, Vancouver BC, V6J 1X1
Phone 604-425-4444 Fax 604-628-3816

REBALANCEMD

PATIENT INFORMATION: (affix label or complete)	**REFERRED BY:** (affix label or complete)
Name:	Name:
PHN:	MSP:
DOB: Gender:	Address:
Address:	Phone:
Home Phone:	Fax:
Alternate Phone:	If applicable Clinic Name:
Email:	
Secondary Contact:	**FAMILY Primary Care Provider and MSP number (if not referring clinician):**
WCB Claim # if applicable:	

DATE:	**Patient to see** "First Available Appropriate Specialist Triage (FAAST)"**?** ❒ **Orthopaedic Surgeon** ❒ **Non-Operative MSK Specialist** ❒ FAAST ❒ No. Prefer to see Dr.:	**URGENT?** ❒ **NON-URGENT** ❒ **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 appropriate surgeon in their health authority.

REASON FOR REFERRAL:

Letter 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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