

Consultation Request

Referring to Specialty: _____

Orthopaedic surgeon

___ Dr. Joseph Menna MD, FRCSC

___ Dr. Jihad Abouali MD, FRCSC

___ Dr. Mina Morcos MD, FRCSC

Pain Medicine

___ Dr. James Khan MD, FRCPC

___ Dr. Sachin Sahni MD, FRCPC

Patient Information	Physician Information
Patient Name:	Physician Name:
DOB:	Address:
Health Card:	Phone:
Address:	Fax:
Home Phone:	Provider Number:
Work Phone:	Specialty:
Cell Phone:	Family Physician: <small>(if not referring MD)</small>
Reason for Referral (Include diagnosis and treatment to date)	
Medical and Surgical History	
Medications	Allergies
Radiology Report Required (Attach recent within 1 year)	
<input type="checkbox"/> MRI <input type="checkbox"/> CT SCAN <input type="checkbox"/> X-ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other _____	
Referring Physician Signature	Date
_____	_____