

Consultation Request

Referring to Specialty: _____

Orthopaedic surgeon Interventional Musculoskeletal Radiology Pain Medicine

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 Attached (If available)				
<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		
_____		_____		