# Musculoskeletal Program – Foot/Ankle Referral

Cornwall Community Hospital  Hôpital Montfort  Queensway Carleton Hospital The Ottawa Hospital  Pembroke Regional Hospital

**Request For Consultation**

**Fax: 613-721-7889**

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| **REFERRAL DATE (YYYY/MM/DD):****\*INCOMPLETE REFERRALS WILL BE RETURNED****\*This referral is not to be used for urgent referrals (e.g. fractures, tendon ruptures)** |
| **Referring Physician Information – may use stamp**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Physician Information (if different)Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Patient Information – may use sticker**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male FemaleAlternate Contact Information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Clinical Information**Diagnosis:Ankle: Right Left BilateralFoot: Right Left BilateralAnkle:

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| --- | --- |
| * Ankle Pain NYD
 | * Ankle Arthritis
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| * Ankle Instability
 | * Talus OCD
 |
| * Achilles Tendinopathy
 | * Other (Specify):
 |

Foot:

|  |  |
| --- | --- |
| * Foot Pain NYD
 | * Midfoot Arthritis
 |
| * Flatfoot
 | * Hallux Valgus
 |
| * Hallux Rigidus
 | * Toe Deformity
 |
| * Charcot Foot
 | * Plantar Fasciitis
 |
| * Other (Specify):
 |  |

**Patient-specific considerations:*** NONE
* Cognitive issues
* Language barrier
* Hearing impairment
* Vision impairment
* Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Does the patient want surgery? | □ yes | □ no |
| Appropriate for virtual visit? | □ yes | □ no |

  | **Treatment to Date**

|  |  |
| --- | --- |
| * None
 | * Physiotherapy
 |
| * Splinting/Footwear
 | * Acupuncture
 |
| * Cortisone injections
 | * Medications
 |
| * Chiropodist/Podiatrist
 | * Other
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**Surgeon Preference*** First Available Surgeon

□ Specific Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Diagnostic Imaging Required:****This referral MUST be accompanied by the imaging report otherwise IT WILL BE RETURNED.** **We REQUIRE the following specific X-rays, including WEIGHT-BEARING views, completed within the last 3 months:****(please note that “routine” views ARE NOT weight-bearing)****Foot:**

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| 1. **weight-bearing AP**
 |
| 1. **weight-bearing lateral**
 |
| 1. **oblique**
 |

**Ankle:**

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| --- |
| 1. **weight-bearing AP**
 |
| 1. **weight-bearing mortise**
 |
| 1. **weight-bearing lateral** (if foot x-rays not done)
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An **MRI/CT scan is NOT RECOMMENDED** for initial screening |