# 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 Female  Alternate Contact Information:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Clinical Information**  Diagnosis:  Ankle: Right Left Bilateral  Foot: Right Left Bilateral  Ankle:   |  |  | | --- | --- | | * Ankle Pain NYD | * Ankle Arthritis | | * 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):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      |  |  |  | | --- | --- | --- | | 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 |   **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:**   |  | | --- | | 1. **weight-bearing AP** | | 1. **weight-bearing lateral** | | 1. **oblique** |   **Ankle:**   |  | | --- | | 1. **weight-bearing AP** | | 1. **weight-bearing mortise** | | 1. **weight-bearing lateral** (if foot x-rays not done) |   An **MRI/CT scan is NOT RECOMMENDED** for initial screening |