Stamp or Sticker (Name, address, phone, HC#)

Urgent MSK Referral
Telephone: 519 661-4135
Fax: 519 850-2484

Referring MD: Name: ____

Billing #:____

Diagnosis/History:

Past Medical History:
No general health problems:

Diabetic Heart Disease

Respiratory Obesity

Smoker Other:

Medications:

Past Surgical History:

Other Treatment:
Physiotherapy?☐

Injection?☐ When?_____________

Orthotics or Brace?☐

NSAIDs?☐

Imaging:
X-Rays: Results____
MRI/CT: ____
Ultrasound: ____

*Note: **If advanced imaging has not been performed there is no need to obtain a scan prior to referral.**

Urgency: < 1 week 1-2 weeks <4 weeks Elective

For Orthopedic Intake Use Only:

Date Received: ______________

Disposition: RL KW RG AG RD

Priority: Urgent Acute Elective

LR