GSSMC Clinic Referral Form V1.8 December 2016

This form can be downloaded at www.glensatherclinic.ualberta.ca

Sport Medicine Physician Referral Form - Fax completed form to: 780-407-5667

To avoid delays, this form must be completed in full

☐ Next Available Appointment     ☐ Specific Physician
☐ Urgent appointment (will be reviewed)

For Clinic Use Only

Appt Date:
Appt Time:

Patient Information:

Name: ____________________________ Gender: ____________________________ DOB (DD/MM/YYYY): ____________________________ Age: ____________________________

Address: __________________________

Phone Number - Home: ____________________________ Cell: ____________________________ PHN: ____________________________

Clinical Details:

☐ Acute injury (<4 weeks)     ☐ Flare-up of Pre-Existing     ☐ Chronic Condition

Injury Date: __________ Body Part: __________________________

1. What was the mechanism of injury?______________________________________________________________

2. What specific sport or activity does the injury prevent the person from doing?______________________________________________________________

3. What is the clinical question to the Sport and Exercise Medicine Physician?______________________________________________________________

4. Treatment received to date for the injury/concern?____________________________________________________________________

Pertinent Past Medical History (attach additional information as needed)

________________________________________________________________________________________

________________________________________________________________________________________

Imaging and/or investigations are not necessary for patient referral. If imaging has been completed please indicate below and forward results to our office. If images are on Netcare, there is no need to send a disc.

☐ X-ray     ☐ CT     ☐ Ultrasound     ☐ MRI     ☐ Bone Scan     ☐ N/A

Referring Health Professional Information (please complete)

Name (Print): ____________________________ PRACID: ____________________________
Mailing Address: ____________________________ Date: ____________________________
Signature: ____________________________
Phone Number: ____________________________ Fax Number: ____________________________

Please do not send referrals for WCB or MVA cases-they will be returned.