THESHOULDERCENTRE

Rouge Valley HEALTH SYSTEM

Date: _____

FAX to (905) 428-5339 or 1-844-484-8722 and indicate First Available or Preferred Surgeon

Referring Physician

Name:
Address:

Billing # :
Telephone:
FAX:
Email:

Type Of Consultation:
☑ In Person Consultation

Assessment By:
☐ First Available *(or choose below)*
☐ Dr. S. Gallay
☐ Dr. J. Hodgins
☐ Dr. J. Smith
☐ Dr. J. Lobo
☐ Dr. J. Slade
Shantz

Patient Information

Name:
Address:

Indicate Preferred Contact Number:
☐ Phone (Home):
☐ Phone (Work):
☐ Phone (Cell):

Date of Birth:
Health Card #: **VC:**
Gender: ☐ Male ☐ Female
Assessment For: ☐ Right ☐ Left
Hand Dominance: ☐ Right ☐ Left
Coverage: ☐ OHIP ☐ WSIB ☐ Self Pay

WSIB Claim Number:

Treatments To Date

Previous Non-operative Treatment:

☐ Physiotherapy ☐ Massage ☐ NSAIDs
☐ Chiropractic ☐ Acupuncture ☐ Narcotic Analgesics

Previous Cortisone Injection:

☐ Subacromial ☐ Glenohumeral
☐ AC Joint ☐ Biceps ☐ None

Response To Injection:

Pain Relief: %
Duration:
None Partial Complete

Previous Shoulder Surgery

Same Side: ☐ Yes ☐ No **Contralateral Side:** ☐ Yes ☐ No

Diagnostic Imaging: (check all that are appropriate and attach reports)

☐ Xray

☐ Glenohumeral OA
☐ Humeral Head Elevation
☐ Bony Bankart Lesion
☐ Hill-Sachs Lesion
☐ Fracture
☐ Dislocation

☐ Ultrasound

☐ Rotator Cuff Tear
Size: cm
☐ Partial Thickness
☐ Full Thickness

☐ MRI ☐ MRArthrogram

☐ Rotator Cuff Tear
Size: cm
☐ Partial Thickness
☐ Full Thickness

☐ Labral Tear

For Internal Use Only

☐ PA(A) ☐ NSP ☐ SHG ☐ JJAL ☐ JSS Rev by: Date:
☐ PA(C) ☐ NSP ☐ JS ☐ JH Appointment:

To help us serve your patients appropriately, and to ensure the most rapid means of referral, please fill out as much information as possible, including the screening questions on page 2 of this referral.
Please include any relevant diagnostic imaging reports, previous consultation notes, or operative notes.

THESHOULDERCENTRE

Rouge Valley HEALTH SYSTEM

Rapid Screening Questions

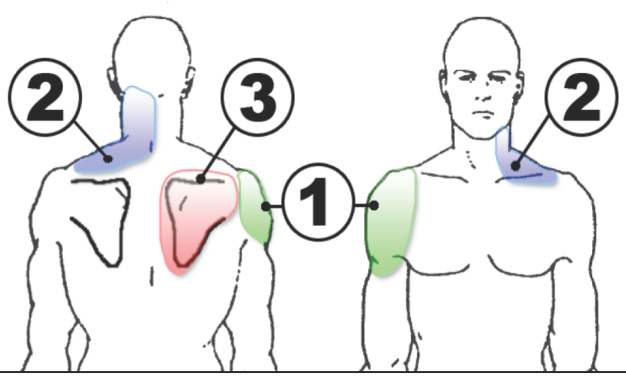
Where is the primary location of pain?
(check all that apply *or* draw on diagram)

☐ **No Pain**

☐ **1** (lateral shoulder)

☐ **2** (neck or trapezius)

☐ **3** (scapula)



When did the condition begin? (exact date if possible, estimate otherwise)

Day: **Month**: **Year**:

☐ **Unknown** ☐ **No specific Injury**

Yes	No	
☐	☐	Was there a traumatic onset? **Describe Injury:**
☐	☐	Was there a fracture or dislocation documented by physical exam or imaging test?
☐	☐	Is there a history of multiple dislocations? If so, indicate number of dislocations:
☐	☐	Within 24 hours of the injury, was the patient unable to raise their arm away from their body?
☐	☐	Is there a prior or recurrent history of this problem?
☐	☐	Is there a history of gradually worsening pain with progressive loss of shoulder motion (especially external rotation)?