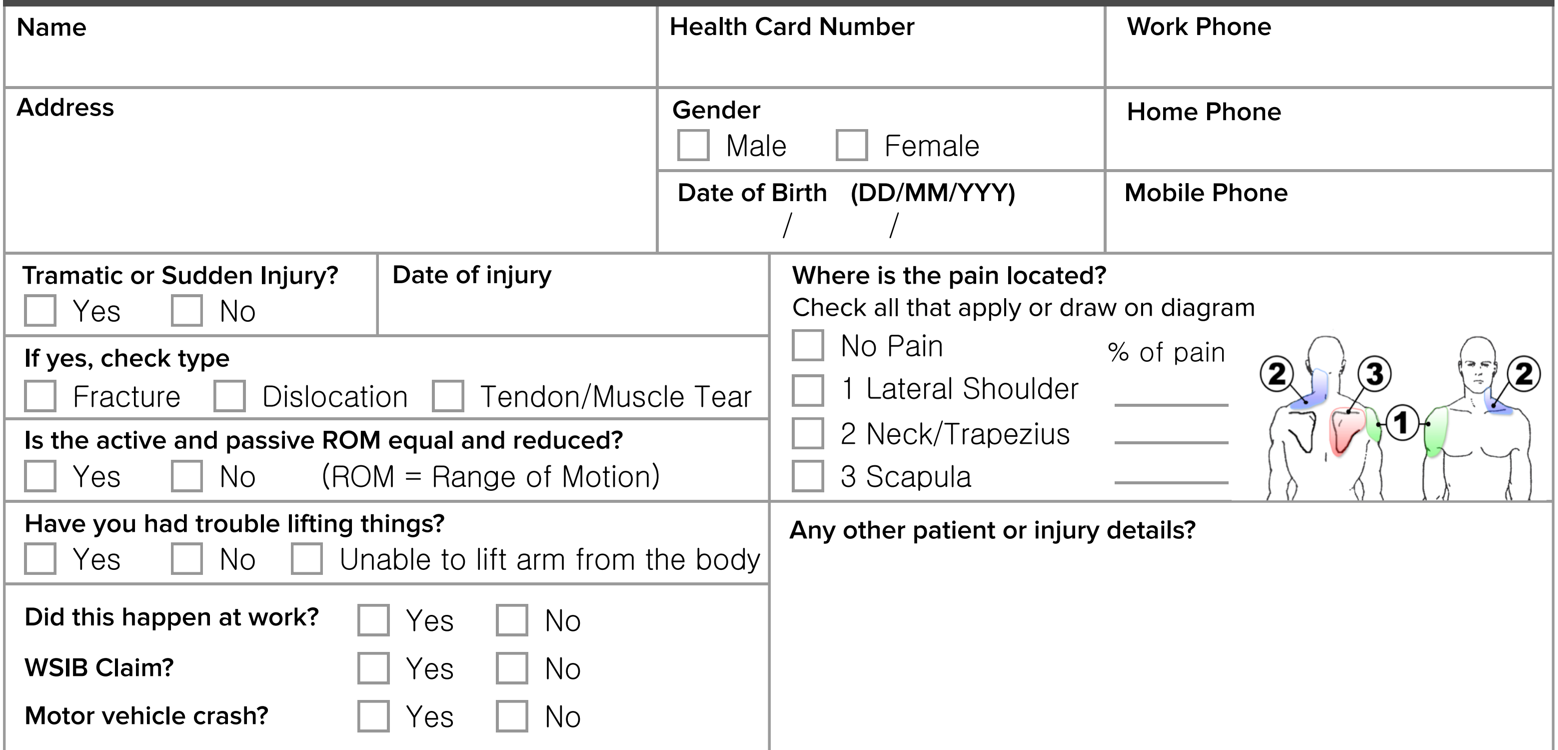
THE**SHOULDER**CENTRE
Located at The Ajax and Pickering Hospital

Lakeridge Health

PATIENT INFORMATION



Name	Health Card Number	Work Phone
Address	Gender ☐ Male ☐ Female	Home Phone
	Date of Birth (DD/MM/YYY) / /	Mobile Phone

Tramatic or Sudden Injury? ☐ Yes ☐ No

Date of injury

If yes, check type
☐ Fracture ☐ Dislocation ☐ Tendon/Muscle Tear

Is the active and passive ROM equal and reduced?
☐ Yes ☐ No (ROM = Range of Motion)

Have you had trouble lifting things?
☐ Yes ☐ No ☐ Unable to lift arm from the body

Did this happen at work? ☐ Yes ☐ No
WSIB Claim? ☐ Yes ☐ No
Motor vehicle crash? ☐ Yes ☐ No

Where is the pain located?
Check all that apply or draw on diagram

	% of pain
☐ No Pain	
☐ 1 Lateral Shoulder	______
☐ 2 Neck/Trapezius	______
☐ 3 Scapula	______

Any other patient or injury details?

TREATMENT TO DATE

Previous Treatment
☐ Physio ☐ Massage ☐ Anti–Inflammatories
☐ Narcotics ☐ Acupuncture

Previous Cortisone Injection
☐ No ☐ Yes, by whom ____________

Site
☐ Subacromial ☐ AC Joint ☐ Glenohumeral

Response to injection
☐ None ☐ Partial ☐ Complete

Duration ____________

Was there a dislocation?
☐ Yes ☐ No

Was it put back in the hospital?
☐ Yes ☐ No

How many times has it dislocated?

Previous assessment by surgeon?
☐ Yes, by whom? ____________ ☐ No

Previous shoulder surgery?

Same side	☐ Yes	☐ No
Contralateral Side	☐ Yes	☐ No

REFERRING PHYSICIAN

Physician Name	Billing #	Assessment by
Address	Tel	☐ **First available**
	Fax	☐ Dr. S Gallay ☐ Dr. J Lobo ☐ Dr. J Hodgins ☐ Dr. M Rollins ☐ Dr. J Smith
Signature		Date

Please send all imaging reports.

FAX to **(905) 428-5339**
and indicate First Available or Preferred Surgeon

To help us serve you better, please fill out as much information as possible.
Please include any relevant imaging reports, previous consultation notes, or operative notes. Thank you.