ORTHOPAEDIC REHABILITATION INSTITUTE
KAWARTHAS

PATIENT REFERRAL & PRESCRIPTION

LOCATION

☐ PETERBOROUGH
1054 MONAGHAN RD
SUITE 102
PETERBOROUGH ON
K9J 5L3
T 705.304.6715
F 833.962.0344
E info@orikawarthas.ca
www.orikawarthas.ca

☐ TORONTO
865 YORK MILLS RD
SUITE 20
TORONTO ON
M3B 1Y6
T 647.349.7880
F 647.349.7550
E info@orthorehab.ca
www.orthorehab.ca

☐ URGENT
(SPECIFY REASON) _____

PATIENT INFORMATION

PATIENT NAME _____

TEL _____

ADDRESS _____

GENDER: ☐ M ☐ F DATE OF BIRTH

MVA ☐ WSIB ☐ EHC ☐ PRIVATE ☐ OHIP ☐

OHIP#: ☐☐☐☐ - ☐☐☐ - ☐☐☐ - ☐☐

REFERRING PHYSICIAN / PRACTITIONER

PHYSICIAN NAME _____

ADDRESS _____

TEL _____ FAX _____

BILLING NUMBER _____

CC FAMILY DOCTOR
(ENTER PHYSICIAN NAME IF APPLICABLE)

DIAGNOSIS / SYMPTOMS _____ DATE OF INJURY / ONSET _____

SPECIFIC CLINICAL QUESTIONS _____

☐ ASSESS ANT TREAT

CONSULTATION FOR THE FOLLOWING (select all that apply)

☐ PHYSIOTHERAPY
☐ MASSAGE THERAPY
☐ MULTIDISCIPLINARY THERAPY REFERRAL
(Patient can be referred on to a specialist physician if no improvement is made. ☐)
☐ ORTHOPAEDIC CONSULTATION: ☐ LOWER EX. ☐ UPPER EX.
(For Upper Extremity, please fill out Kawarthas Upper Extremity Form.)

☐ PROCEDURAL MEDICINE / INJECTIONS
☐ BRACING / ORTHOTICS
☐ COMPLEX TRAUMA / MVA
☐ CHRONIC PAIN CONSULTATION (Toronto Location Only)

SUPPORTING INFORMATION

Please attach Patient Cumulative Profile and any imaging report. Please tell patient to bring a CD of their imaging.

REFERRING PHYSICIAN / PRACTITIONER

SIGNATURE _____ DATE _____

REASON FOR REFERRAL

☐ SHOULDER PROBLEM ☐ RIGHT ☐ LEFT ☐ BILATERAL

- ☐ Impingement
- ☐ AC Arthrosis
- ☐ Instability ☐ Atraumatic ☐ Traumatic
- ☐ Glenohumeral ☐ Osteoarthitis
- ☐ Rotator Cuff ☐ Degenerative ☐ Traumatic
- ☐ Other: _____ ☐ Not Yet Diagnosed

☐ ELBOW PROBLEM ☐ RIGHT ☐ LEFT ☐ BILATERAL

- ☐ Osteoarthitis ☐ Degenerative ☐ Traumatic
- ☐ Instability ☐ Atraumatic ☐ Traumatic
- ☐ Epicondylitis ☐ Medial ☐ Lateral
- ☐ Cubital Tunnel Syndrome
- ☐ Other: _____ ☐ Not Yet Diagnosed

☐ WRIST / HAND ☐ RIGHT ☐ LEFT ☐ BILATERAL

- ☐ Degenerative Wrist ☐ Degenerative ☐ Traumatic
- ☐ Carpel Tunnel Syndrome
- ☐ TFCC Injury
- ☐ Arthritis of the Hand
- ☐ Other: _____ ☐ Not Yet Diagnosed

SYMPTOM DURATION

☐ < 2 WEEKS ☐ 2 - 6 WEEKS
☐ 6 - 12 WEEKS ☐ 3 - 6 MONTHS
☐ 6 - 12 MONTHS ☐ > 12 MONTHS

☐ LEVEL OF PAIN ☐ Mild ☐ Moderate ☐ Severe

☐ FUNCTIONAL IMPAIRMENT ☐ Mild ☐ Moderate ☐ Severe

NON-OPERATIVE MANAGEMENT ATTEMPTED

	Effective	Partially effective	Not appropriate for me	Unable	Don't want to try	Not attempted
PHYSIO OR OTHER THERAPY	☐	☐	☐	☐	☐	☐
NSAID	☐	☐	☐	☐	☐	☐
JOINT INJECTION (location _____)	☐	☐	☐	☐	☐	☐
BRACING	☐	☐	☐	☐	☐	☐

IS THIS PATIENT WISHING TO PURSUE SURGERY? ☐ Yes ☐ No ☐ Patient Uncertain

ANY ADDITIONAL INFORMATION

PARTICIPATING PHYSICIAN / PRACTITIONER

☐ FIRST AVAILABLE
☐ DR. WONG
☐ SPORTS MEDICINE
☐ ADVANCED PRACTICE PHYSIOTHERAPIST
☐ ORTHOPAEDIC SURGEON (Visiting)

SIGNATURE

DATE