Humber River Hospital

Shoulder - Orthopaedic Consultation Request
Central Intake

FAX: 1-855-346-9138

MSK Central Region - Central Intake

Referral Date: YYYY	MM	DD

☐ Preferred Surgeon, Dr. ________________________ or ☐ First Available Surgeon

Referring Physician Information

Name: ________________________
Address: ________________________
____
Phone: ________________________
Fax: ________________________
Billing #: ________________________
Signature: ________________________

Family Physician Information (if different)

Name: ________________________
Phone: ________________________

Patient Information

Name: ________________________
Address: ________________________
____
Date of Birth: ________________________
Health Card #: ____________ VC: ____________

Gender: ☐ Male ☐ Female

Language if unable to speak English: ________________

Phone: ________________________

Alternate Phone: ________________________

Clinical Information

Etiology: ☐ Non-traumatic ☐ Traumatic ☐ Overuse ☐ WSIB ☐ MVC

Treatment to date: ☐ Analgesics ☐ NSAID ☐ Injections ☐ Exercise ☐ Physiotherapy ☐ Surgery

Other treatments: ____

Shoulder: ☐ Right ☐ Left

☐ Rotator cuff disorder or tear
☐ Inflammatory arthritis
☐ Osteoarthritis
☐ Instability/ labral tear
☐ Acromioclavicular joint
☐ Impingement syndrome
☐ Frozen shoulder
☐ Other

IMAGING REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL

To be accepted into the shoulder RAC program, we kindly ask for the following DI within the last 12 months:

Shoulder:
☐ X-ray: AP shoulder, lateral
☐ U/S

Please ensure that imaging reports are included in the referral. Patients should bring either DVD or access codes to allow viewing of X-rays, or MRI (if available)

** Note: Please ensure all sections of this referral are fully completed. Referrals that do not have accompanying imaging will not be accepted. This referral is not to be used for urgent cases e.g. fractures, tendon ruptures **