

CHEO ORTHOPEDICS FRACTURE & INJURY REFERRAL FORM

Referral Process

1. Please complete the form below for **FRACTURE & INJURY** consults. There is another form for other orthopedic concerns. Please be as detailed as possible. If there is not enough detail, the referral will be denied. Feel free to add a letter to support this form. **Areas with an * must be filled/checked.**
2. Inform the patient/family that **CHEO will contact them in 3 to 5 days** to setup an appointment time.
3. Fax this completed form to **613-738-4865**.

If applicable, **please provide the patient with any medical imaging** (unless on NEODIN/CNER) and advise to bring to their appointment.

Orthopedic Emergencies (24/7)

For all Orthopedic **emergencies**, call **613-737-7600 ext. 0** and ask for the On-Call Orthopedic Resident.

Examples of emergencies include:

- A) Opinion on fractures requiring a reduction,
- B) Fractures for surgical opinion,
- C) Other orthopedic emergencies.

**** Please note: To refer a patient for routine follow up in the Fracture Clinic, paging on-call Ortho is NOT required ****

PLEASE PLACE PATIENT LABEL OR PRINT CLEARLY

*Name		*Referring Hospital Name	
*DOB (dd/mm/yyyy)		*Referring Provider	
*Phone #		*Provider Billing #	
Address			

Reason for Referral

<input type="checkbox"/> Fracture	<p>*Date of injury: _____</p> <p>*Bones Involved: <input type="checkbox"/> Spine <input type="checkbox"/> Clavicle <input type="checkbox"/> Humerus <input type="checkbox"/> Radius/Ulna <input type="checkbox"/> Scaphoid <input type="checkbox"/> Pelvis <input type="checkbox"/> Femur <input type="checkbox"/> Tibia/Fibula <input type="checkbox"/> Ankle <input type="checkbox"/> Foot</p> <p>*Fracture Type: <input type="checkbox"/> Avulsion <input type="checkbox"/> Greenstick <input type="checkbox"/> Buckle <input type="checkbox"/> Involves physis/growth plate <input type="checkbox"/> Does not involve physis/growth plate <input type="checkbox"/> Other</p>	<p>*Location: <input type="checkbox"/> Right <input type="checkbox"/> Left</p> <p>*Fracture Movement: <input type="checkbox"/> Displaced <input type="checkbox"/> Undisplaced</p> <p>*Reduction performed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*Type of immobilization: <input type="checkbox"/> None <input type="checkbox"/> Splint <input type="checkbox"/> Air Boot <input type="checkbox"/> Short Cast <input type="checkbox"/> Long cast <input type="checkbox"/> Sling</p>
<input type="checkbox"/> Acute Injury <small>*Acute shoulder injury and ACL injury require MRI prior to consult</small>	<p>*Date of injury: _____</p> <p>*Bone/Joint Involved: <input type="checkbox"/> Neck/C-Spine <input type="checkbox"/> Shoulder <input type="checkbox"/> Elbow <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Ankle</p> <p>*Type of Injury: <input type="checkbox"/> Dislocation <input type="checkbox"/> New ligamentous injury/tear <input type="checkbox"/> New meniscus tear <input type="checkbox"/> Patellar instability with fracture/loose body <input type="checkbox"/> Other</p> <p>*Immobilization: <input type="checkbox"/> None <input type="checkbox"/> Sling <input type="checkbox"/> Splint <input type="checkbox"/> Long Cast <input type="checkbox"/> Short Cast <input type="checkbox"/> Air boot <input type="checkbox"/> C-Collar <input type="checkbox"/> Other</p>	<p>*Location: <input type="checkbox"/> Right <input type="checkbox"/> Left</p>