CHEO

ORTHOPEDICS SPORTS MEDICINE REFERRAL FORM

Referral Process

1. Please complete the form below for all SPORTS MEDICINE concerns. **There are separate forms for fracture or acute injury and general orthopedics referrals**. 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 to set up an appointment time.
3. Fax this completed form and all relevant imaging reports 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.*

Patient Information – PLEASE PLACE PATIENT LABEL OR PRINT CLEARLY

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

Reason for Referral

UPPER EXTREMITY

☐ **Shoulder**	☐ Recurrent Shoulder Instability (☐ *MRI w/ contrast included) ☐ Other (e.g.: SC joint, AC joint, little league shoulder): ______________________
☐ **Elbow**	☐ Elbow/Capitellar OCD ☐ Elbow throwing injuries ☐ Other: ______________________
☐ **Other**	______________________

LOWER EXTREMITY

☐ **Hip** ***A 3 month trial of PT is required for all FAI and Labral Tear referrals***	☐ Adolescent Hip Dysplasia ☐ FAI (* PT x ____ months) ☐ Labral tear (* PT x ___ months) ☐ Other: ______________________
☐ **Knee** ***A 3 month trial of PT is required for all patellofemoral pain referrals***	☐ ACL Tear (☐ *MRI included) ☐ Chronic Meniscal Pathology (e.g.: chronic tear, etc.) ☐ Osteochondritis Dissecans (OCD) or Other Osteochondral Lesion ☐ Recurrent Patellofemoral Instability ☐ Patellofemoral pain (*PT x ____ months) ☐ Other ligamentous tear ☐ Other: ______________________
☐ **Foot and Ankle**	☐ Recurrent Ankle Instability ☐ Osteochondritis Dissecans (OCD) or other Osteochondral Lesion ☐ Peroneal Subluxation ☐ Os Trigonum ☐ Accessory Navicular
☐ **Other**	______________________