Queensway Carleton Hospital

FOOT AND ANKLE SCREENING AND TRIAGE CLINIC

REFERRAL FORM

Patient name:	Birth date (yy/mm/dd):
Address:	Postal code:
Home phone #:	Alternate phone #:
OHIP number:	☐ WSIB ☐ Other:_____
Referring hospital (if applicable):	
Family Physician (if different from below):	Phone #:

REASON FOR REFERRAL

☐ **Right**	☐ **Left**	☐ **Foot**	☐ **Ankle**
☐ Bunion	☐ Toe deformity	☐ Morton's neuroma	☐ Ganglion cyst / fibroma
☐ Arthritis	☐ Tendinopathy	☐ Plantar fasciitis	☐ Other:

REFERRING PHYSICIAN

Name: **Billing #:**

Address:

Phone #: **Fax #:**

Signature:_____ **Date (yy/mm/dd):**_____

If available, send or fax the following information with referral

1. **Patient Cumulative Profile**
2. **Consults:** Orthopedic consult letter, Orthopedic operative report, Podiatry consult
3. **Reports:** i.e. CT scan, MRI scan, bone scan
4. **X-Ray:** Must be standing view of involved foot and ankle within the last 3 months
5. **Medication list**

QUEENSWAY CARLETON HOSPITAL ■ 3045 BASELINE ROAD
OTTAWA, ONTARIO K2H 8P4
■ ☎ (613) 721-2000 EXT 3756 ■ FAX (613) 613-721-2032

An electronic copy of this form is available on the QCH Website – see Clinics