Musculoskeletal Program – Foot/Ankle Referral

Cornwall Community Hospital ■ Hôpital Montfort ■ Queensway Carleton Hospital
The Ottawa Hospital ■ Pembroke Regional Hospital

Request For Consultation

Fax: 613-721-7889

REFERRAL DATE (YYYY/MM/DD):

***This referral is not to be used for urgent referrals (e.g. fractures, tendon ruptures)**

Referring Physician Information – may use stamp

Name: _____
Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____
Billing #: _____
Signature: _____

Family Physician Information (if different)
Name: _____
Phone: _____

Patient Information – may use sticker

Name: _____
Address: _____
_____
Phone: _____
Date of Birth: _____
Health Card #: _____
Gender: Male Female
Alternate Contact Information:
_____
_____
_____

Clinical Information

Diagnosis:
Ankle: Right Left Bilateral
Foot: Right Left Bilateral

Ankle:
☐ Ankle Pain NYD
☐ Ankle Arthritis
☐ Ankle Instability
☐ Talus OCD
☐ Achilles Tendinopathy
☐ Other
Specify: _____

Foot:
☐ Foot Pain NYD
☐ Midfoot Arthritis
☐ Flatfoot
☐ Hallux Valgus
☐ Hallux Rigidus
☐ Toe Deformity
☐ Charcot Foot
☐ Plantar Fasciitis
☐ Other
Specify: _____

Treatment to Date

☐ None
☐ Physiotherapy
☐ Anti-Inflammatories
☐ Narcotics
☐ Massage
☐ Acupuncture
☐ Splinting/Shoes
☐ Cortisone Injection(s)
☐ Other

Surgeon Preference:

☐ First Available Surgeon
☐ Specific Surgeon: _____

Diagnostic Imaging:
We recommend the following views:

☐ Foot: **weight-bearing AP/lateral and oblique X-rays** of the foot **within the last 3 months**
☐ Ankle: weight-bearing AP

An **MRI/CT scan is NOT RECOMMENDED** for initial screening

Programme régional musculosquelettique

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