Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

Lower Extremity Foot/Ankle Consultation Request Form

Instructions:
To facilitate prompt and appropriate assessment/consultation of your patient by an orthopaedic surgeon, please:

1. Complete this form and provide all requested information.
2. **Sign** and **Date** the bottom of the second page.
3. Fax form and radiology report to appropriate fax number (see attached directory).

NB: CONTACT SURGEON DIRECTLY IF THIS IS AN EMERGENCY

COMPLETING THIS FORM DOES NOT GUARANTEE ACCEPTANCE OF THIS PATIENT

Consult directed to:

◯ Next available surgeon ◯ Specific Surgeon: _____

Referral Type:

☐ New ☐ Repeat ☐ WCB ☐ WCB Appeal ☐ MPIC ☐ Medical Legal ☐ 2nd Opinion

Patient Demographics (Please print clearly. Use label if available): ◯ Female ◯ Male

Last Name: _____ First Name: _____

DOB: ☐☐☐☐ / ☐☐ / ☐☐ (Y Y Y Y / M M / D D) MHSC: _____ PHIN: _____

Tel: (Home) _____ (Work) _____ (Other) _____

Address (Include postal code) _____

Does patient read and speak English? ◯ Yes ◯ No

Referring Physician: _____

Address: _____

Phone: _____ Fax: _____

Radiology: A copy of a plain x-ray report of the relevant joint(s) is required for us to assess this request. Foot and ankle films should be done standing.

☐ Plain x-ray Date _____ Location _____

☐ Other: _____ Date _____ Location _____

☐ _____ Date _____ Location _____

Reason for Referral:

☐ Ankle Problem ◯ Right ◯ Left ◯ Bilateral

Diagnosis: ☐ Instability ☐ Rheumatoid ☐ Impingement

☐ OCD ☐ Other _____

☐ Osteoarthritis: ☐ Post Traumatic ☐ Degenerative

◯ Mild ◯ Moderate ◯ Severe

☐ Foot Problem ◯ Right ◯ Left ◯ Bilateral

Diagnosis: ☐ Bunion

☐ Claw/Hammer Toes

☐ Osteoarthritis: ☐ Midfoot ☐ Forefoot

☐ Soft Tissue Disorder _____

Symptom Duration: ◯ < 2 weeks ◯ 2-6 weeks ◯ 6-12 weeks ◯ 3-6 months

◯ < 6-12 months ◯ 12-24 months ◯ >24 months

VAS Pain Score (patient rated):

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Minimal pain Worst pain ever

Athletic Level: ◯ None ◯ Recreational ◯ Highly Competitive ◯ Professional

Non-operative Management Attempted:

	Effective	Partially effective	Not appropriate for me	Unable	Don't want to try	Not attempted
Physio or Other Therapy	◯	◯	◯	◯	◯	◯
NSAID	◯	◯	◯	◯	◯	◯
Joint Injection (location_____)	◯	◯	◯	◯	◯	◯
Bracing	◯	◯	◯	◯	◯	◯
Orthotics	◯	◯	◯	◯	◯	◯

Is this patient wishing to pursue surgery? ◯ Yes ◯ No ◯ Patient Uncertain

History / Medications / Allergies / Social (attach separately if preferred): _____

_____

_____

Signature of referring physician: _____ **Date:** _____