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

Shoulder Consultation Request Form

*** 1. Include Xray report (all cases - AP, Outlet, and Axillary views) ***

*** 2. Include any other investigations, if done (MRI, CT Scan) ***

*** 3. Fax signed form and radiology report to appropriate fax number (see attached directory) ***

~~ NB: CONTACT SURGEON DIRECTLY IF THIS IS AN EMERGENCY ~~

Consult request for: ◯ 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 (yyyy/mm/dd): _____/_____/____ MHSC: _____ PHIN: _____

Patient Age: ____ Tel Home: _____ Work: _____ Other: _____

Home Address (including postal code): _____

Support Person Name: _____ Support Person Telephone: _____

Referring Physician: _____ Phone: _____

Address: _____ Fax: _____

Reason for Shoulder Referral (initially choosing between *shoulder pain* or *shoulder instability*)

◯ **Shoulder Pain**: ◯ Right ◯ Left ◯ Both

- ☐ Impingement, append MRI to referral
- ☐ AC Joint Arthritis, append MRI to referral
- ☐ Glenohumeral Arthritis ☐ OA ☐ RA
- ☐ Frozen Shoulder / Loss of Passive Range of Motion, append MRI to referral
- ☐ Rotator Cuff Tear ◯ Acute (< 3 months) ◯ Chronic (>3 months), and append MRI to referral
- ☐ Tumour (contact Surgeon on-Call), append MRI to referral

◯ **Shoulder Instability (Dislocation)**: ◯ Right ◯ Left ◯ Both

- ◯ First time
- ◯ Recurrent (>1) (If ≤50 append CT Scan, If >50 append MRI)

◯ **Other Shoulder Issue** Describe: _____

Symptom Duration: ◯ less than 3 months ◯ 3 – 6 months ◯ 6 – 12 months ◯ >12 months

Non-Operative Management Attempted to date:

☐ Physio or other therapy ☐ Medication ☐ Joint Injection

Medical History, including medications and allergies (list or attach):

_____

_____

_____

_____

Signature of Referring Physician: _____ Date: _____