Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Upper Extremity 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:_____ Phone:_____

Address: _____ Fax:_____

Radiology: A copy of a plain x-ray report of the relevant joint(s) is required for us to assess this request. MRI is necessary for soft tissue shoulder problems.

◯ Plain X-ray Date _____ Location _____

◯ Other: _____ Date _____ Location _____

_____ Date _____ Location _____

History / Medications / Allergies / Social (Attach separately if preferred):

Reason for Referral:

Shoulder Problem ○ Right ○ Left ○ Bilateral

Diagnosis:
- ○ **Impingement**
- ○ **AC Arthrosis**
- ○ **Instability** ○ Atraumatic ○ Traumatic — Number of Dislocations:____
- ○ **Glenohumeral** ○ Osteoarthritis
- ○ **Rotator Cuff** ○ Degenerative ○ Traumatic — Size of Tear on MRI:____
- ○ **Other:**_____

Elbow Problem ○ Right ○ Left ○ Bilateral

Diagnosis:
- ○ **Osteoarthritis** ○ Degenerative ○ Traumatic
- ○ **Instability** ○ Atraumatic ○ Traumatic
- ○ **Loose Body** ○ OCD ○ Traumatic
- ○ **Tendon Rupture:** specify:_____ ○ Acute ○ Chronic
- ○ **Other:**_____

Wrist Problem ○ Right ○ Left ○ Bilateral

Diagnosis:
- ○ **Carpal Instability** ○ Degenerative ○ Traumatic
- ○ **Carpel Tunnel Syndrome**
- ○ **Degenerative Wrist**
- ○ **TFCC Injury**
- ○ **Other:**_____

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

1 minimal pain — 10 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
Phyisio or Other therapy	○	○	○	○	○	○
NSAID	○	○	○	○	○	○
Joint Injection (location_____)	○	○	○	○	○	○
Bracing	○	○	○	○	○	○

Is this patient wishing to pursue surgery? ○ Yes ○ No ○ Patient uncertain

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