footbridge
Centre for Integrated Orthopaedic Care

REFERRAL FORM

DATE: _____

PLEASE FAX TO: 778-945-6775

NOTE: All patients require **MEDICAL IMAGING** for triage (see reference sheet for views).

PATIENT INFORMATION *(AFFIX LABEL/ COMPLETE)**	**REFERRING PHYSICIAN** *(AFFIX LABEL/COMPLETE)*
NAME: _____	NAME: _____
DOB (Y/M/D): _____	MSP #: _____
PHN: _____	ADDRESS: _____
PHONE: _____	PHONE: _____
EMAIL: _____	FAX:

Please provide all the requested information. Patients are contacted via email to book their appointment and complete online intake forms. Incomplete referrals will be returned to your office.

Patient to see **FIRST AVAILABLE APPROPRIATE** doctor?**

☐ YES ☐ NO: Prefer to see Dr. _____

Duration of Symptoms (Circle): 8-12 Wks 3-12 Mos. 12+ Mos

***All referrals are managed by our Centralized Intake System & triaged by physicians to ensure your patients obtain an appointment with the firsts-available, most-appropriate physician.**

ACUTE INJURY CLINIC?

☐ **YES**

DATE OF INJURY: _____

WCB CLAIM # ICBC CLAIM #

REASON FOR REFERRAL

☐ KNEE ☐ HIP

☐ FOOT ☐ ANKLE

☐ SHOULDER ☐ ELBOW

☐ OTHER: _____

RIGHT LEFT BOTH

Dx:

Rx:

Investigations:

Previous Medical/Surgical Hx:

Medications:

URGENT REFERRALS:

Patients requiring assessment within 15 days (ie: suspicion of infection or fracture) should call our office directly: 778-945-6756 xt 112 and follow up on the faxed referral.

OUR PHYSICIANS

Dr. Michelle Brousson * Dr. Ali Chaudhary * Dr. Teri Fisher * Dr. Sara Forsyth * Dr. Jordan Leith
Dr. Parth Lodhia * Dr. Murray Penner * Dr. Hooman Sadr * Dr. Keith Stothers * Dr. Andrea Velkjovic
Dr. Mike Wilkinson * Dr. Kevin Wing * Dr. Alastair Younger

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