Thunder Bay Regional Health Sciences Centre

Lake of the Woods District Hospital

RAPID ACCESS CLINIC

SHOULDER REFERRAL FORM

Place Patient Label with Barcode Here

Guidelines:

1. Referring Physician to complete referral form.
2. Referral is to be faxed to the Rapid Access Clinic at 1-844-497-2445
3. The Rapid Access Clinic clerk will receive the referral form and route to the appropriate health care provider.
4. Completed referrals will be filed in the Rapid Access Clinic on the patient's health record.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Gender ☐ Male ☐ Female

Health Card Number: _____ Date of Birth: _____ Age:_____

Day Month Year

Address: _____ City: _____ Postal Code: _____

Phone Number: ( ) _____ Alternate Phone Number: ( )

Hand Dominance: ☐ Right ☐ Left **Affected shoulder:** ☐ Right ☐ Left ☐ Bilateral

Occupation: _____ **WSIB** ☐ yes ☐ no **MVC** ☐ yes ☐ no

Duration of symptoms or date of onset:_____

Acute/Traumatic Injury: ☐ No ☐ Yes

If yes, ☐ fracture ☐ dislocation ☐ tendon rupture/tear

If dislocation, number of episodes____ (#), required in hospital reduction___ (#)

Patient injury details/primary complaint

_____

_____

Where is the pain located?
Check all that apply or draw on diagram.

	% of pain
☐ No Pain	
☐ 1-Lateral Shoulder	_____
☐ 2-Neck/Trapezius	_____
☐ 3- Scapula	_____



Is active and passive ROM equal and reduced? ☐ yes ☐ no Are they unable to lift arm away from their body? ☐ yes ☐ no

***Please attach patient profile, medication list and other pertinent information**

Smoker ☐ yes ☐ no **ETOH/other substances**_____

***Recent shoulder X-rays including AP (anterior posterior), transcapular lateral and axillary lateral views are mandatory for triage. No other imaging is required but if other imaging has been done please include reports.**

TREATMENT TO DATE FOR THIS PROBLEM

☐ Physiotherapy ☐ Anti-Inflammatory
☐ Narcotics ☐ Other_____
☐ Steroid Injection Date_____
Site ☐ subacromial ☐ glenohumeral ☐ acromioclavicular
By whom_____
Response ☐none ☐partial ☐complete
Duration_____

Previous assessment by surgeon? ☐ No ☐ Yes
If Yes, by whom? _____
Date_____ (DD/MM/YYYY)
Previous shoulder surgery? ☐ Right ☐ Left
Procedure:_____
Date: _____(DD/MM/YYYY)

SURGEON/HOSPITAL OPTIONS

☐ First available surgeon ☐ Preferred Surgeon_____ ☐ Preferred Site_____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____ Billing Number: _____

Address:_____ Telephone: _____ Fax: _____