JUSTIN S. CHANG
ORTHOPAEDIC SURGEON

REQUEST FOR ORTHOPAEDIC CONSULTATION

PLEASE FAX REFERRALS TO: (416) 291-5554

Referral Date (YYYY-MM-DD):

Referring Physician Information: Name: Specialty: Address: Phone: Fax: Email: Billing #: Signature: **Family Physician Information (if different):** Name: Phone:	**Patient Information:** Name: Address: Date of Birth: Health Card #: VC: Gender: Male / Female Language if unable to speak English: Phone (Home): Phone (Work): Phone (Cell): Email:
Diagnosis (circle all that apply): Hip: Right / Left Knee: Right / Left Osteoarthritis Inflammatory arthritis Fracture/Post-traumatic arthritis Painful hip or knee replacement Meniscus Injury or ACL Rupture Sports Injuries Patellofemoral Disorders	**Consideration for:** Primary Replacement: Hip / Knee Opinion on prior replacement: Hip / Knee Arthroscopic meniscal surgery ACL reconstruction Sports surgery (other) Injections: Hip/Knee Non-Surgical Opinion: Hip / Knee
Past Medical History:	**Current Medications:**

Please attached existing imaging reports. If your patient has had imaging at an external clinic, please advise them to bring a CD with the images to their appointment.