MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

ORTHOPAEDIC SURGERY
FRACTURE CLINIC REFERRAL FORM

TEL: (416) 469-6384 FAX: (416) 469-6424

REF

Patient ID Label

☐ **Routine** ☐ **Urgent**

Patient Last Name:	Given Name:	☐ M ☐ F	Date of Birth: (DD / MMM / YYYY)
Address:	Apt#:		Telephone Number – Primary Number: ( )
Town or City:	Province:	Postal Code:	Telephone Number – Work Number: ( )
Contact Person (Caregiver/Parent/Guardian:	Relationship To Patient:		Telephone Number - Contact Person: ( )

Family Physician:	**Ontario Health Card Number:** Version Code	**Email Address For Virtual Consult:**

Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown

Required Questions:	PRIVACY: If we call the patient, can we leave a voice message?	☐No	☐Yes
	WSIB: Is this treatment due to a work related injury?	☐No	☐Yes
	American Sign Language interpreter required?	☐No	☐Yes
	Language interpreter required? - specify:	☐No	☐Yes

Referred To:

☐ **First Available Appointment**

☐ Dr. Abouali ☐ Dr. Chang ☐ Dr. Kraemer ☐ Dr. Weiler

☐ Dr. Catre ☐ Dr. Higgins ☐ Dr. Tsvetkov ☐ Dr. Wong

Referral Date:

Reason For Referral:

☐ Second Opinion ☐ Started with Injury ☐ WSIB Assessment ☐ Other:

Investigations To Date: ☐ X-ray ☐ CT ☐ MRI ☐ Ultrasound ☐ Lab Tests ☐ Procedures Notes ☐ Consultation Notes ☐ Other Tests:

Past Medical History:

Medications:

Referring Physician:

Physician Name:	
Telephone Number: ( )	Fax Number: ( )
Physician's Signature:	Billing#:

Appointment Information:		**RTS TC Reference ID:**	

Ocean by CognisantMD — Ontario eServices Program

We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at **eReferral@ehealthce.ca**