

Date: **Sports Medicine Clinic Referral**

**Referring Physician**

Name \_\_\_\_\_ Billing # \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Signature \_\_\_\_\_

**Patient**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Prov. Health # \_\_\_\_\_ Expiry yyyy-mm-dd \_\_\_\_\_ Birth Date yyyy-mm-dd \_\_\_\_\_  
Phone \_\_\_\_\_ Language:  Eng  Fr  Eng & Fr  
 WSIB  MVA  Varsity

**Conditions Best Treated Elsewhere:**

✓ **Patients with axial neck and back pain without arm or leg symptoms.**

Management of axial neck & back pain does not require specialist consultation as it entails: i) use of prn analgesia (Tylenol, NSAIDs, muscle relaxants), ii) education on remaining active and reassure that despite pain they will not do harm, iii) physio for stretching and strengthening, and iv) education on ergonomics. More information and resources, including a patient education & self-management video can be found at [www.ontario.ca/lowbackpain](http://www.ontario.ca/lowbackpain). One may also consider a diagnostic and therapeutic trial of facet joint injections or medial branch blocks. These referrals can be sent to radiology at the Ottawa Hospital, or the Kingston Orthopedic Pain Institute.

✓ **Patients with generalized chronic pain syndromes such as fibromyalgia.**

**Referral To**

**General/Sports Medicine**  **Orthopaedic Surgery**  **Physiatry/Sports Medicine**

*Or indicate a specific Provider*

Dr. Valerie Hindle  Dr. Chris Raynor  Dr. Gerald Wolff  
 Dr. Gary Greenberg  Dr. Michael Pickell  Dr. Colin Mascaro  
 Dr. Sean Mindra  
 Dr. Pauline Lin

**Details**

**Priority**  Urgent  Routine **Date of Injury** \_\_\_\_\_ **Activity/Sport Affected** \_\_\_\_\_

**Nature of Injury**  Acute (Less than 4 weeks)  Subacute (Less than 6 mo. duration)  Chronic condition **(See conditions best treated elsewhere for exclusions.)**

**Body Part**  Shoulder/Arm  Hip/Pelvis  Elbow/Forearm  Knee/Leg  Wrist  Foot/Ankle

**Spine**  Cervical  Thoracic  Lumbar

**Diagnosis**  Arthritis  Fracture  Soft Tissue Injury  Other \_\_\_\_\_

**Imaging**

Please note that imaging is required for referrals to Ortho/Sports Medicine but imaging and/or investigations are not necessary for patient referral to general sports medicine or physiatry. If imaging has been completed please indicate below and forward results to our office.

Ultrasound  X-Ray  MRI  CT  EMG  N/A

**Reason for Referral** \*(Please attach past medical/surgical history, medication list and allergies as required)