DURHAM BONE & JOINT SPECIALISTS

65 BAYLY STREET WEST, LEVEL 1, SUITE 100
AJAX, ON L1S 7K7

Phone: (905) 426 - 2233

Website: DBJS.HEALTH

FAX REFERRALS TO (905) 426 - 3306

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

DD / MM / YY ○ M ○ F ○ OTHER
DATE OF BIRTH

Street, City, Province, Postal Code
ADDRESS

Primary #
TELEPHONE NUMBER EMAIL

HEALTH CARD # WSIB CLAIM #

REFERRING PHYSICIAN	CPSO#	BILLING#	DATE

AREA OF CONCERN:

☐ SHOULDER ☐ HIP ☐ FOOT
☐ ELBOW ☐ KNEE ☐ OTHER:_____
☐ WRIST ☐ ANKLE

LATERALITY:

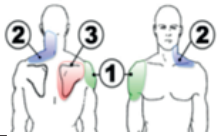
☐ RIGHT
☐ LEFT
☐ BILATERAL

TRAUMATIC / SUDDEN INJURY:

☐ APPROXIMATE DATE OF INJURY___Months___ DURATION OF SYMPTOMS___Months___
☐ DETAILS OF INJURY_____

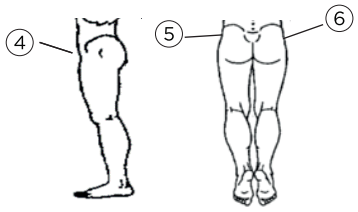
LOCATION OF PAIN? (Check All That Apply)

☐ DIFFUSE
☐ 1 - LATERAL SHOULDER ___%
☐ 2 - NECK / TRAPEZIUS ___%
☐ 3 - SCAPULA ___%

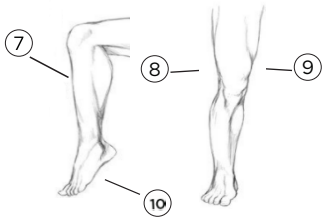


☐ PAIN 24/7
☐ INCREASING SHOULDER STIFFNESS
☐ ACTIVE & PASSIVE SHOULDER ROM REDUCED
☐ XRAY NEGATIVE FOR JOINT ARTHRITS

☐ 4 - HIP ANTERIOR / GROIN ___%
☐ 5 - HIP LATERAL / TROCHANTER ___%
☐ 6 - HIP POSTERIOR / BUTTOCK ___%



☐ 7 - KNEE ANTERIOR ___%
☐ 8 - KNEE MEDIAL ___%
☐ 9 - KNEE LATERAL ___%
☐ 10 - FOOT / ANKLE



FUNCTION (SANE SCORE): _____/100 (100= NORMAL FUNCTION) **PAIN SCORE: _____/10 (10=MAX)**

PREVIOUS SURGERY? ☐YES ☐NO DATE OF SURGERY: _____
Please Include Operative Note if Available

LIKELY DIAGNOSIS:

☐ OSTEOARTHRITIS

☐ SOFT TISSUE INJURY
- ☐ LIGAMENT TEAR
  SPECIFY LIGAMENT: _____
- ☐ TENDON/MUSCLE TEAR
  SPECIFY TENDON: _____

☐ SHOULDER INJURY
- ☐ SHOULDER IMPINGEMENT
- ☐ FROZEN SHOULDER
- ☐ DISLOCATION
  # of DISLOCATIONS: _____

☐ MINOR FRACTURE

☐ OTHER: _____

PLEASE INDICATE PREFERRED PROVIDER

☐ FIRST AVAILABLE

OR

Lower Extremity	*Upper Extremity*
☐ DR. ABUZGAYA	☐ DR. GALLAY
☐ DR. BENFAYED	☐ DR.KOWALCZUK
☐ DR. FROMBACH	☐ DR. LOBO
☐ DR. LOBO	☐ DR. ROLLINS
☐ DR. RAVICHANDIRAN	

IMAGING REQUIRED

Imaging Reports Are Required to Accept Referral. Imaging Must Be Completed Within 6 Months Prior to Referral.
Please Send All Referrals with Cumulative Patient Profile (CPP).

Shoulder:
Xrays: AP, Trans-Scapular Lateral & Axillary Views
Ultrasound: Shoulder

Hip: AP Pelvis & True Lat Hip
Weight-Bearing Knee Series: AP/Lat & Skyline (Patella view)
Weight Bearing Ankle: Oblique, AP and lateral
Weight Bearing Foot: Dorsoplantar, Lateral and Oblique

PLEASE FAX REFERRALS (WITH CPP & DIAGNOSTIC IMAGING REPORT) TO (905) 426-3306
Referrals Sent to DBJS Will be Managed in Accordance to the Process Required by Rapid Access Clinic and The Shoulder Centre