KHOSHBIN ORTHOPAEDICS

Patient Referral Form

Direct anterior hip replacement, revision hip reconstruction, and trauma

St. Michael's Hospital, Toronto

Fax completed form to: 416-359-1601

Office 416-864-5265

Fill in on your computer, print, and fax. Please do not send patient health information by email.

REFERRAL DATE _____ PRIORITY ☐ Routine ☐ Urgent

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH (DD/MM/YYYY) _____ HEALTH CARD NUMBER _____ PHONE _____

ADDRESS

REASON FOR REFERRAL

☐ Hip osteoarthritis ☐ Revision / failed replacement ☐ Second opinion

☐ Trauma / fracture ☐ Other

SIDE ☐ Left ☐ Right ☐ Bilateral

CLINICAL DETAILS AND QUESTION FOR THE SURGEON

RELEVANT HISTORY, SYMPTOMS, PREVIOUS TREATMENT, AND THE QUESTION YOU WOULD LIKE ADDRESSED

IMAGING

X-RAY ☐ Low AP pelvis ☐ Lateral ☐ Affected hip

☐ MRI ☐ CT ☐ None

WHERE IMAGING WAS DONE / PACS _____

REFERRING PHYSICIAN

NAME _____ BILLING NUMBER _____

PHONE _____ FAX _____ DATE _____

SIGNATURE _____

Khoshbin Orthopaedics

Martin Family Centre, Ground Floor, Donnelly Wing North, St. Michael's Hospital, 30 Bond Street, Toronto, ON M5B 1W8

Fax: 416-359-1601

For acute trauma, contact the hospital directly through the usual on-call pathway rather than by routine fax referral.