Shoulder Referral
Request for Consultation

2068, 9499 – 137 Avenue,
Edmonton, Alberta T5E 5R8
Phone: 780.433.3155
Fax: 780-457-4393

PATIENT INFORMATION:

Last Name________________________ First Name__________________ PHN: ___________-_________

Gender ☐ Male ☐ Female Date of Birth ________ /________ / ________
D M Y

Address: _____________________ City: _______________________ Postal Code: ______________

Phone: (_____)_______________ Alt. Phone: (_____)_______________ Email: ____________________

REFERRING PHYSICIAN INFORMATION:

Name__________________________________ Pracid: ___________________

Address: _____________________ City: _______________________ Postal Code: ______________

Phone: (_____)_______________ Fax: (_____)_______________ Email: ____________________

REASON FOR REFERRAL (please attach relevant history):

Affected side: ☐ Right ☐ Left ☐ Bilateral

☐ Rotator Cuff Injury/Disease

☐ Glenohumeral Arthritis ☐ Acromioclavicular Arthritis

☐ Instability

☐ Frozen Shoulder

☐ Failed Surgery – please attach operative reports and other pertinent investigations

☐ Other ____

Requested Surgeon Name: Last_____________________ First_____________________

Next Available Surgeon: ☐ Yes ☐ No

WCB Patient?: ☐ Yes ☐ No WCB#___________________________

X-RAY/IMAGING *****Attach any imaging that has been completed to referral*****

Please note: imaging <u>is not</u> required for referral acceptance

NON SURGICAL TREATMENTS ATTEMPTED (check all that apply):

ATTEMPTED	RESULT	ATTEMPTED	RESULT
Physiotherapy	☐ Good ☐ Moderate ☐ No relief	Injections	☐ Good ☐ Moderate ☐ No relief
NSAID/COXIB	☐ Good ☐ Moderate ☐ No relief	Narcotics	☐ Good ☐ Moderate ☐ No relief
Other __________	☐ Good ☐ Moderate ☐ No relief	Chiropracty	☐ Good ☐ Moderate ☐ No relief

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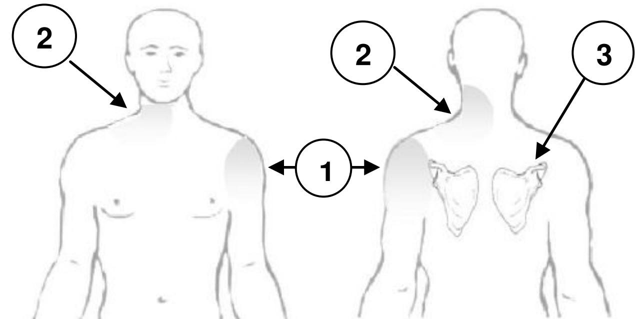
RAPID SCREENING QUESTIONS

Where is the primary location of pain?
(check all that apply and/or draw on the diagram)

☐ No Pain
☐ 1 (lateral shoulder)
☐ 2 (neck or trapezius)
☐ 3 (scapula)
☐ Other __________________



Duration Of Symptoms:

☐ Weeks ☐ Months ☐ Years ☐ Unknown

When did the symptoms begin? (exact date if possible) _________________

☐ Yes	☐ No	Was there a traumatic onset? Date: ___________ Describe Injury:
☐ Yes	☐ No	Was there a fracture or dislocation identified by physical examination or an imaging test?
☐ Yes	☐ No	Is there a history of multiple dislocations? If yes indicate the number of dislocations:
☐ Yes	☐ No	Within 24 hours of the injury was the patient unable to raise their arm away from their body?
☐ Yes	☐ No	Is this a recurrent problem?
☐ Yes	☐ No	Is there a history of worsening pain with progressive loss of shoulder motion?
☐ Yes	☐ No	Is there significant loss of external rotation?

Referring Physician Signature: ________________________________ **Date:** ________ /________ /________
D M Y