DR. CHRISTIAN VEILLETTE MD, MSc, FRCSC
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Shoulder & Elbow Reconstructive Surgery

ORTHOPAEDIC CONSULTATION REFERRAL
Toronto Western Hospital · Sprott Department of Surgery
399 Bathurst St, McLaughlin Wing 13-419, Toronto ON M5T 2S8
Phone: (416) 603-5929 · **Fax:** 1-866-223-6624
Web: www.drcvortho.ca · **Email:** office@drcvortho.ca

REFERRAL INSTRUCTIONS: Please fax completed referral form along with diagnostic imaging reports (X-rays, MRI, CT, ultrasound) and pertinent clinical notes to **1-866-223-6624**. Patients with acute fractures, tendon ruptures, or rapid neuromuscular compromise are triaged urgently within 48-72 hours.

1. PATIENT DEMOGRAPHICS

Full Legal Name: _____	**Date of Birth (YYYY-MM-DD):** _____
Health Card Number (OHIP): _____ **Version:** ____	**Biological Sex: [ ] Male [ ] Female [ ] Other**
Primary Phone: _____ **Alt Phone:** _____	**Email:** _____
Mailing Address: _____	**City / Postal Code:** _____

2. REFERRING PHYSICIAN / PRACTITIONER

Referring MD / NP Name: _____	**Billing / CPSO #:** _____
Clinic / Hospital Name: _____	**Phone:** _____ **Fax:** _____
Clinic Address: _____	**Family MD (if different):** _____

3. CLINICAL INDICATION & JOINT OF CONCERN

Affected Joint: [ ] Right Shoulder [ ] Left Shoulder [ ] Bilateral Shoulder **[ ] Right Elbow [ ] Left Elbow [ ] Bilateral Elbow**	**Triage Urgency:** **[ ] Urgent (1-2 weeks): Acute tear/fracture/instability** **[ ] Priority (2-6 weeks): Progressive pain/subluxation** **[ ] Routine (Elective): Chronic arthritis/stiffness**
Specific Shoulder Condition: **[ ] Rotator Cuff Tear (Partial / Full / Massive)** **[ ] Glenohumeral Osteoarthritis (Candidate for Arthroplasty)** **[ ] Cuff Tear Arthropathy (Reverse Replacement Candidate)** **[ ] Anterior / Posterior Instability (Bankart / Latarjet)** **[ ] Failed Previous Shoulder Surgery / Arthroplasty Revision** **[ ] Pectoralis Major Tendon Rupture** **[ ] AC Joint Pathology / Clavicle Nonunion** **[ ] Biceps Pathology / SLAP Lesion**	**Specific Elbow Condition:** **[ ] Distal Biceps Tendon Rupture (Acute / Chronic)** **[ ] Total Elbow Arthroplasty / Arthritis Candidate** **[ ] Resistant Epicondylitis (Lateral / Medial)** **[ ] Elbow Instability (MCL / LUCL Tear)** **[ ] Post-Traumatic Stiffness / Capsular Contracture** **[ ] Triceps Tendon Rupture** **[ ] Ulnar Neuropathy / Cubital Tunnel Syndrome** **[ ] Loose Bodies / Osteochondritis Dissecans (OCD)**

4. DIAGNOSTIC IMAGING & WORKUP COMPLETED

Imaging Performed:
[ ] Plain Radiographs (AP, True AP, Axillary, Scapular Y) — Date: _____ **Facility:** _____
[ ] MRI / MR-Arthrogram — Date: _____ **Facility:** _____
[ ] CT Scan (3D Glenoid Reconstruction) — Date: _____ **Facility:** _____
[ ] Diagnostic Ultrasound — Date: _____ **Facility:** _____

**Note: If imaging was completed outside ConnectingOntario (e.g. out-of-province or private imaging clinic), please provide patient with digital image CD/USB to bring to consultation.*

5. PHYSICIAN SIGNATURE & SUBMISSION

Referring Physician Signature: _____ **Date (YYYY-MM-DD):** _____

Please Fax Completed Form to 1-866-223-6624 *· Confirmation will be faxed back with appointment details.*