

**Fracture Clinic**  
**REFERRAL FORM**

Brampton Civic Hospital  
2100 Bovaird Drive East  
Phone: 905-494-2120 x 56577  
Fax: 905-494-6509

Patient Identification

Referral source:  Emergency Department  Acute Care  Primary Health Care MD

**Diagnosis:** \_\_\_\_\_

**Date of Injury:** \_\_\_\_\_

**INCLUSION CRITERIA**

- Acute adult fractures (upper and lower extremity) – ideally seen within 1 week of injury
- Pediatric fractures – ideally seen within 2 days of injury
- Acute soft tissue injuries of the musculoskeletal system
- less than 8 weeks old\*
- Tendon injuries (excluding hand)
- Muscle tears and intramuscular hematomas
- Traumatic joint effusions
- Post-operative complications as a result of surgery at BCH - book with operative surgeon
- Recurring symptoms related to original diagnosis (within 3 months of discharge from fracture clinic). Book with original consulting surgeon. If more than 3 months patients should call surgeon's office directly to schedule an appointment
- Hip and knee arthroplasty concerns/infections

**EXCLUSION CRITERIA**

- Soft tissue injuries of the musculoskeletal system greater than 8 weeks Pediatric fractures – ideally seen
- Chronic musculoskeletal conditions
- Low back pain – refer to Spine Centre Spine and pelvic fractures – refer to Spine Centre\*\*
- Hand fractures – refer to Plastic Surgery
- Soft tissue lacerations – refer to Plastic Surgery
- Soft tissue infections not involving joint or bursa

\*\* Spine Centres: Trillium Hospital, Toronto Western Hospital, St. Michael's Hospital, Sunnybrook Hospital

Referrals will be screened. If they do not meet inclusion criteria, they will be returned with suggestions for re-direction.

**\*All relevant imaging results must accompany referral.**

**In the case of an obvious fracture, an imaging report is not required, but online/CD radiographs performed outside Osler must be obtained by and accompany patient on initial visit to fracture clinic.**

**Patient Information**

Patient's Last Name: \_\_\_\_\_ Patient's First Name: \_\_\_\_\_

Date of Birth: (DD/MM/YY) \_\_\_\_\_ Gender: M  F  Other

Healthcard #: \_\_\_\_\_ VC \_\_\_\_\_ No OHIP

Address: \_\_\_\_\_ City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone # (primary) \_\_\_\_\_ Phone # (alternate) \_\_\_\_\_ Cell #: \_\_\_\_\_

**Referring Clinician Information**

Referring Clinician name: \_\_\_\_\_ OHIP Billing number: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

