William Osler Health System

Fracture Clinic
REFERRAL FORM

Etobicoke General Hospital
115 Humber College Blvd 4th floor
Phone: 416-740-3400 x 32529
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 weeksold*
- Tendon injuries (excluding hand)
- Muscle tears and intramuscular hematomas
- Traumatic joint effusions
- Post-operative complications as aresult ofsurgeryat EGH - book with operative surgeon
- Recurring symptoms related to original diagnosis (with in 3 months of discharge fromfracture clinic).
- Book with original consulting surgeon. If morethan 3 months, patients should call surgeon's office directly to schedule an appointment.
  Diabetic foot ulcer (direct the referral to Dr. Quinn)

EXCLUSION CRITERIA

- Soft tissue injuries of the musculoskeletal system greater than 8 weeks
- Chronic musculoskeletal conditions
- Low back pain – refer to Spine Centre
- Spine and pelvic fractures – refer to Spine Centre**
- Hand fractures – refer to Plastic Surgery (or direct the referral to Dr. Kember)
- Soft tissue lacerations – refer to Plastic Surgery
- Arthroplasty infection – refer to operative surgeon
- 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 #: _______________________________

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