Sask Foot & Ankle Pooled Referral Form www.saskfootankle.com **Fax: 306-244-4545**

PATIENT:	Last Name:		First Name:
Date of Birth:	Address:		
City:	Prov:	PC:	HSN:
Home Phone:	Work Phone:		Cell Phone:
E-Mail:			

REFERRING PRACTITIONER & CLINIC INFORMATION:

☐ Family Doctor
☐ Specialist
☐ Other: _____

Name:
Address:
Phone:
Fax:

REFERRAL TO:

☐ Next Available Surgeon Except Dr.

☐ Specific Surgeon: ☐ Multi-Disciplinary Non-Op Foot & Ankle Clinic

☐ **ELECTIVE** ☐ **URGENT (INDICATE REASON)** _____

REASON FOR REFERRAL:

ORTHOPEDIC CONCERN	☐ Left ☐ Right ☐ Foot ☐ Ankle

Preliminary Diagnosis (Please be as specific as possible to ensure proper prioritization of patients)

ADDITIONAL INFORMATION	Duration of Symptoms: Mobility Concerns: ☐ None ☐ Walking Aids ☐ Household ☐ Wheelchair Treatment to Date: ☐ None ☐ Analgesics/Narcotics ☐ NSAIDS ☐ Bracing ☐ Physiotherapy ☐ Other: ☐ Joint Injections

Radiographic Information Required

Must be within the last 6 months. Please send x-ray reports for affected joint
Standard Radiologic Information: Standing AP, mortise ankle, Standing AP, oblique lateral foot (5 views total)

Optional Information:

☐ CT ☐ MRI Location:

Additional Information:

For further information, please visit our website
www.saskfootankle.com

Physician Signature:	Date: