

Orthopedic Trauma, Foot and Ankle Surgery

Victoria Hospital, London Health Sciences Centre - London, Ontario

(For Urgent Orthopedic Injuries or Fracture Referrals, please fax to 519-685-8447)

First Available Surgeon (Shortest Wait time) Fax: 519-685-8059

Dr. Mark MacLeod **Dr. David Sanders** **Dr. AbdelRahman Lawendy** **Dr. Christopher Del Balso**
P - 519-685-8000 x53059 P - 519-685-8086 P - 519-685-8218 P - 519-667-6815
F - 519-685-8059 F - 519-685-8016 F - 519-685-8267 F - 519-667-6816

Referral Information:

Date: _____	Referring Physician: _____
Ref. Physician Phone: _____	Ref. Physician Billing #: _____
Ref. Physician Fax: _____	

Patient Information:

Name: _____	Health Card No: _____	VC: _____
DOB: _____	Phone No: _____	Alt Phone No: _____
Address: _____		
*Email address: _____		

Reason for Referral: **URGENT** **ELECTIVE** **Date of Injury?** _____

Previous Investigations? (Please attach all imaging reports)	MRI/CT <input type="checkbox"/>	XRAY <input type="checkbox"/>	U/S <input type="checkbox"/>	When? _____
				Where? _____
Has the patient previously been seen by an Orthopedic surgeon for this?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Who/When?	
Is the patient interested in surgery?	YES <input type="checkbox"/>	NO <input type="checkbox"/>		

~ Please attach any additional information that pertains to your patient's surgical eligibility ~

OFFICE USE ONLY:

Referral Acknowledgment Date: _____	
PRIORITY – 1 - 6 MONTHS <input type="checkbox"/>	Please Note
RE-REFERRAL – UP TO 12 MONTHS <input type="checkbox"/>	Your patients appointment
ELECTIVE – NO PRIORITY <input type="checkbox"/>	details will be sent at a later date.

To request an electronic copy of this form please email:
jennifer.thorne@lhsc.on.ca
or
stephanie.machado@lhsc.on.ca