



**DIRECT ACCESS COMMUNITY PHYSICIAN REFERRAL FORM**  
Use *ONLY* for Acute Orthopaedic Injury Follow-up

Name: \_\_\_\_\_ Mr/Mrs/Miss/Ms  
LAST FIRST (SPECIFY)

Address: \_\_\_\_\_

Contact Number: ( ) \_\_\_\_\_ HC # \_\_\_\_\_ VC \_\_\_\_\_ DOB: \_\_\_\_\_  
YYYY /MM /DD

Referring MD: \_\_\_\_\_ Billing # \_\_\_\_\_  
PRINT

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

**Please note:**

- this clinic is for ACUTE orthopaedic injuries only
- plastics consultation is not available
- please inform patients to bring Imaging films & CD's to the appointment
- All referrals are triaged by clinic staff and are booked accordingly with the most appropriate practitioner

**Diagnosis / History:**

**Referring Physician's Signature:**

**Please advise patients:**

- Please do not send in your patient without an appointment. The **clinic will call your patient directly** regarding their appointment time and will fax back to your office confirmation on the appointment time.
- Patients should bring their **health card, imaging films & CD's** to their appointments
- The clinic is located on the first floor of the West lobby of NYGH-Leslie Site
- Charges apply for non-plaster products

***Orthopaedic and Plastics Clinic Use Only***

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ COMMENTS: \_\_\_\_\_