SCOPE Orthopaedic Consultation Referral Form

** Please fax this referral form to 416-521-4140 **

Patient's Name (please print):	**Patient's Heath Card Number & Version Code:**
Patient's Date of Birth:	**Patient's Phone Number:**
Patient's Home Address:	
Reason for Referral:	
Relevant History and Comorbidities:	
Relevant Investigations:	
Current Medications:	
Allergies:	☐No Known Allergies
Referring PCP's Name:	**Referring PCP's Signature:**
Billing #	**Date:**
I hereby refer the above noted patient to the SCOPE Orthopaedic Clinic and a physician specialist or program as appropriate.	

Eligibility for the SCOPE Ortho Clinic:

1. Patient >18 years of age
2. No MVA, WSIB or patients with established chronic pain disorders
3. Orthopaedic musculoskeletal issues only (e.g. joint arthritis, low back pain, neck pain, tendinitis, cuff tears etc.).