



SPORT MEDICINE PHYSICIAN CONSULTATION REQUISITION

10 Howland Dr. Unit #1, Huntsville, Ontario P1H 1M3 | 705.789.7600 | PLEASE FAX TO 705.789.1509

Patient Name:	Phone Number:
Health Card #:	Date of Birth:

WSIB, MVA & LITIGATION REFERRALS WILL NOT BE ACCEPTED

Urgency

- Routine Non-urgent
- As soon as possible
- Urgent (<2 weeks)

Request Consultant

- Dr. Rich Trenholm
- Dr. Pierre Mikhail
- First available physician

URGENT CASES: Primary Care Providers are asked to please contact our office to initiate an urgent referral request. Alternatively, Drs. Trenholm and Mikhail can be reached through the switchboard at HDMH, (705) 789-2311.

Sport and Exercise Medicine Concern

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|---|--|---------------------------------------|--|
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Shoulder/Rotator Cuff | <input type="checkbox"/> Elbow | <input type="checkbox"/> Wrist/Hand |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Upper Extremity | <input type="checkbox"/> Chest | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Hip | <input type="checkbox"/> Lower Extremity | <input type="checkbox"/> Ankle/Foot | <input type="checkbox"/> Hamstring |
| <input type="checkbox"/> Thoracic Spine | <input type="checkbox"/> Neck/Cervical Spine | <input type="checkbox"/> Lumber Spine | <input type="checkbox"/> Medical Concern in Sport & Exercise |
| <input type="checkbox"/> Other: _____ | | | |

Affected Side **Right** **Left** **Bilateral**

If the patient has **MULTIPLE** complaints that are unrelated, **send individual referrals**. This is to ensure an appropriate amount of time is taken for each consultation.

Investigations Attached

- | | | | |
|---|-----------------------------------|---|--|
| <input type="checkbox"/> MRI | <input type="checkbox"/> X-Ray | <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> CT | <input type="checkbox"/> Lab Work | <input type="checkbox"/> Consultation Letters | <input type="checkbox"/> Office & ER Notes |
| <input type="checkbox"/> Bilateral Standing X-ray if the referral is for Knee Osteoarthritis prior to the appointment to improve the efficiency of your patient's care. | | | |

Brief History & Summary of Physical Findings

see attached document office or ER visit

Referring MD/ NP Name & Signature	OHIP Number	Date
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Sport Medicine Doctor's **do not create home exercise programs**, this doesn't allow for effective rehabilitation. Please refer to our **physiotherapy and athletic therapy** specialists for an assessment and creation of an effective home exercise program.