**Acute Knee Injury Clinic (AKIC) Referral Form – For Soft Tissue Injury Only**

**Please do not send referrals for WCB or MVA cases.**

**This clinic is for patients 13 – 55 years old who have sustained injuries within 1 month of the date of referral. Multi-ligamentous (3+) injuries, fractures, open wounds, or neurovascular injuries should be seen emergently by consulting the orthopaedic surgeon on call and NOT through this clinic.**

**Date of Referral: Patient Information:**

|  |
| --- |
| **Affix patient label here** |

**Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Contact Phone Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complete the following questions:**

1. Injury Date**:**  Affected Knee: □ Right □ Left
2. How were you injured – describe the event:
3. Did this knee problem occur due to an injury or accident? □ Yes □ No
(If you answered yes to question 3 please complete questions 3a, b & c below)

	1. Did you hear or feel a “pop” at the time of your injury or accident? □ Yes □ No
	2. If this injury or accident occurred during activity, were you able to
	complete the activity? □ Yes □ No
	3. Did your knee swell within 24 hours of the injury or accident? □ Yes □ No
4. Before this current knee injury or accident, have you ever injured either knee before?
□ No □ Yes If yes, please describe (include date)

X-rays required:

* AP and lateral of the affected knee(s)

**MRI is not necessary for referral.**

**If the referral is accepted the Patient will be contacted within 3 business days for an appointment.**

Referring Health Professional Information **(must be completed in full)**:

Name (Print): Date: \_\_\_\_\_\_

Mailing Address: **PRACID**: Signature:

Phone Number: Fax Number:

 **Fax completed form to: 780-407-5667**