

www.glensatherclinic.ualberta.ca Edmonton Clinic, Level 2 11400 University Avenue, Edmonton AB T6G 1Z1   
P: 780-407-5160

**Sport Medicine Physician Referral Form - Fax completed form to: 780-407-5667**To avoid delays, this form must be completed in full

□ Next Available Appointment □ Specific Physician

|  |
| --- |
| **For Clinic Use Only**  Appt Date:  Appt Time: |

□ Urgent appointment (will be reviewed)

**Patient Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: | Gender: | DOB (DD/MM/YYYY): | Age: |
| Address: | | | |
| Phone Number - Home: Cell: PHN: | | | |

**Clinical Details:** □ Acute injury (<4 weeks)

□ Flare-up of Pre-Existing

**Injury Date:** \_\_\_\_\_\_\_\_\_\_\_\_**Body Part(s):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Chronic Condition

1. Describe the mechanism of injury.

2. What specific sport or activity does the injury prevent the person from doing?

3. What is the clinical question to the Sport and Exercise Medicine Physician?

4. Treatment received to date for the injury/concern?

5. Pertinent Past Medical History? (attach additional information as needed)

Imaging and/or investigations are not necessary for patient referral. If imaging has been completed please indicate below and forward results to our office. If images are on Netcare, there is no need to send a disc.

□ X-ray □ CT □ Ultrasound □ MRI □ Bone Scan □ N/A

**Referring Health Professional Information (please complete)**

Name (Print): PRACID:

Mailing Address: Date:

Signature:

Phone Number: Fax Number:

**Please do not send referrals for WCB or MVA cases-they will be returned.**