Santé et Services sociaux Québec

DT9295

ORTHOPEDIC CONSULTATION ADULT

Note: Refer to the clinical alerts on the back of the form and favor, if available, the protocols of the Accueil Clinique before filling it out.

Patient's first and last name

Health insurance number | Expiry: Year Month

Parent's first and last name

Area code Phone number | Area code Phone number (alt.)

Address

Postal code

Reason for consultation — **Clinical priority scale: A: ≤ 3 days B: ≤ 10 days C: ≤ 28 days D: ≤ 3 months E: ≤ 12 months**

*** Treatment = 3 months of physiotherapy and 2 infiltrations done**

Shoulder	☐ Complete tears of the rotator cuff proven by MRI or ultrasound (patient < age 50) *(Prerequisite: MRI or ultrasound report)*	C
	☐ Rotator cuff disease (bursitis, tendonitis, impingement, chronic rotator cuff tear, tendinosis) *(Prerequisite: treatment* failure and MRI or ultrasound report)*	D
	☐ Recurrent shoulder dislocation with physiotherapy initiated *(Prerequisite: x-ray report, MRI arthrogram)*	D
	☐ Disabling osteoarthritis of the shoulder *(Prerequisite: treatment* failure and x-ray report)*	D
Elbow	☐ Complete distal biceps tendon rupture	B
	☐ Epicondylitis and epitrochleitis *(Prerequisite: treatment* failure and ultrasound or MRI report)*	D
Knee	Complete rupture of tendon: ☐ Patellar ☐ Quadriceps	B
	☐ Cruciate ligament rupture with physiotherapy initiated *(Prerequisite: MRI report)*	C
	☐ Acute or traumatic meniscal tear (< age 60) *(Prerequisite: MRI report)*	D
	☐ Disabling osteoarthritis of the knee *(Prerequisite: treatment* failure and x-ray report)*	D
Foot/Ankle	☐ Complete Achilles' tendon rupture	B
	☐ Persistent severe sprain ankle with treatment failure (symptoms persisting for over 2 months despite immobilization and physio) *(Prerequisite: x-ray and MRI)*	C
	☐ Disabling osteoarthritis of the ankle *(Prerequisite: treatment* failure and x-ray or MRI report)*	D
	☐ Hallux valgus or symptomatic hammer toes *(Prerequisite: x-ray report)*	E
Others	☐ Minor acute non-displaced immobilized[1] fracture or acute subluxation *(Prerequisite: x-ray)*	B
	☐ Musculoskeletal tumors *(Prerequisite: x-ray)*	B
	☐ Persistent severe wrist sprain (symptoms lasting over 2 months despite splint and physio) *(Prerequisite: MRI report and x-ray)*	C
	☐ Disabling osteoarthritis of the hip *(Prerequisite: treatment* failure and x-ray report)*	D
	☐ Carpal tunnel or ulnar tunnel syndrome confirmed by EMG *(Prerequisite: EMG report)*	C

☐ **Other reason for consultation or clinical priority modification *(MANDATORY justification in the next section)*:**

Clinical priority

Suspected diagnosis and clinical information (mandatory)

If prerequisite is needed:

- ☐ **Available in the QHR (DSQ)**
- ☐ **Attached to this form**
- ☐ **Treatment* failure**

Special needs:

Referring physician identification and point of service

Referring physician's name | Licence no.

Area code Phone no. | Extension | Area code Fax no.

Name of point of service

Signature | Date (year, month, day)

Stamp

Family physician: ☐ **Same as referring physician** ☐ **Patient with no family physician**

Family physician's name

Name of point of service

Registered referral (if required)

If you would like a referral for a particular physician or point of service

Clinical alerts (non-exhaustive list)

Refer the patient to the Emergency-department

- Open fracture with or without neurovascular complications
- Unreduced dislocation
- Compartment syndrome
- Septic arthritis
- Cauda equina syndrome

(1) **Fracture immobilisation:**

For fracture immobilisation, you are encouraged not to refer patients to the Emergency-department, but rather to use the service corridors available in your area.