Centric Health
Orthopaedics
Your Care. Our Focus.

Calgary Orthopaedic Foot and Ankle Clinic

Patient Referral Form

REFERRING PHYSICIAN INFORMATION:

NAME:

ADDRESS:

POSTAL CODE:

TEL#: _____

FAX#: _____

PRACID#: _____

PATIENT INFORMATION:

NAME: **M☐** **F☐**

ADDRESS:

POSTAL CODE:

TEL#: _____

AHC#: _____

REFERRAL TO:

☐ Hugh R. Dougall, MD, FRCS(C)
☐ Ian L.D. Le, MD, FRCS(C)
☐ Iain S. Russell, MD, FRCS(C)
☐ Brent D. Haverstock, DPM, FACFAS
☐ Phil M. LeLievre, DPM, FACFAS
☐ Next Available Appointment

REASON FOR REFERRAL:

☐ Right ☐ Left
☐ Forefoot
☐ Hindfoot
☐ Ankle
☐ Achilles Tendon
☐ Diabetic Foot
☐ Injury
☐ Developmental
☐ Congenital
☐ Complication
☐ 1st MTP Joint
☐ Post-Traumatic
☐ Limb Deformity
☐ Rheumatoid Foot
☐ Rheumatoid Ankle
☐ Plantar Fascia

☐ Assess Patient Clinically to Develop Treatment Plan
☐ Second Opinion

IMAGING

☐ X-ray ☐ Bone Scan ☐ Ultrasound ☐ CT Scan ☐ MRI

Please have copy of images and report forwarded to our office. X-rays should be weight-bearing.

Physician Signature: _____

CLINIC USE ONLY

☐ Office
1.___ 2.___ 3.____ 4.____

☐ PLC Cast Clinic

Referral Received: _____/_____/_____ **dd/mm/yy**

Appointment Scheduled: _____/_____/_____ **dd/mm/yy**

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centrichealth.ca