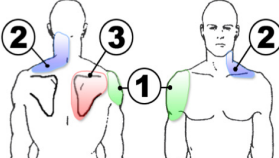




PATIENT INFORMATION

Name		Health Card Number	Work Phone
Address		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone
		Date of Birth (DD/MM/YYYY) / /	Mobile Phone
Tramatic or Sudden Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of injury	Where is the pain located? Check all that apply or draw on diagram	
If yes, check type <input type="checkbox"/> Fracture <input type="checkbox"/> Dislocation <input type="checkbox"/> Tendon/Muscle Tear		<input type="checkbox"/> No Pain _____ % of pain <input type="checkbox"/> 1 Lateral Shoulder _____ <input type="checkbox"/> 2 Neck/Trapezius _____ <input type="checkbox"/> 3 Scapula _____	
Is the active and passive ROM equal and reduced? <input type="checkbox"/> Yes <input type="checkbox"/> No (ROM = Range of Motion)			
Have you had trouble lifting things? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to lift arm from the body		Any other patient or injury details?	
Did this happen at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
WSIB Claim? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Motor vehicle crash? <input type="checkbox"/> Yes <input type="checkbox"/> No			

TREATMENT TO DATE

Previous Treatment <input type="checkbox"/> Physio <input type="checkbox"/> Massage <input type="checkbox"/> Anti-Inflammatories <input type="checkbox"/> Narcotics <input type="checkbox"/> Acupuncture	Was there a dislocation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Previous Cortisone Injection <input type="checkbox"/> No <input type="checkbox"/> Yes, by whom _____	Was it put back in the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No
Site <input type="checkbox"/> Subacromial <input type="checkbox"/> AC Joint <input type="checkbox"/> Glenohumeral	How many times has it dislocated?
Response to injection <input type="checkbox"/> None <input type="checkbox"/> Partial <input type="checkbox"/> Complete Duration _____	Previous assessment by surgeon? <input type="checkbox"/> Yes, by whom? _____ <input type="checkbox"/> No
	Previous shoulder surgery? Same side <input type="checkbox"/> Yes <input type="checkbox"/> No Contralateral Side <input type="checkbox"/> Yes <input type="checkbox"/> No

REFERRING PHYSICIAN

Physician Name	Billing #	Assessment by
Address	Tel	<input type="checkbox"/> First available
	Fax	<input type="checkbox"/> Dr. S Gallay
Signature		<input type="checkbox"/> Dr. M Rollins <input type="checkbox"/> Dr. S Chhabra
		<input type="checkbox"/> Dr. J Lobo
		Date

Please send all imaging reports.

FAX to (905) 428-5339
and indicate First Available or Preferred Surgeon