

North Bay Regional Health Centre
Orthopedic Services
Orthopedic Outpatient Clinic Referral

Please complete all sections and FAX to 705 495 8106. Ensure imaging has been pushed to NBRHC PACS.

1. PATIENT INFORMATION

Name: _____
Date of Birth: _____ (DD/MM/YYYY)
Ontario Health Card #: _____
Other insurance Provider (if no OHIP) _____
Address: _____
Telephone#: _____
Alternate#: _____
Family Provider: _____

Have you contacted the NBRHC ON-Call Ortho Surgeon? Y N

Name of Ortho Surgeon: _____

Diagnosis (include body part): _____

Laterality Left or Right

Mechanism of injury and other relevant information or comments:

Is patient's affected limb casted/immobilized? Y N

If Yes, specify in what has been put in place? _____

 Circumferential cast Splint Brace Sling Other: _____

Indicate what Imaging has been completed

 CT
 MRI
 Xray
 US

Patient imaging is required to process this referral. Ensure patient's imaging been sent to NBRHC PACS? Y N

Date: _____ Referring Provider (print): _____

 Provider Signature: _____

 Provider billing #: _____