Hamilton Health Sciences

# FRACTURE CLINIC PATIENT REFERRAL

**Clinic Located at McMaster Children's Hospital Site**
1200 Main St. West 905-521-2100 ext 73088

** Accurate and Legible completion of this referral is essential **

The following form MUST be completed by the referring Physician or Nurse Practitioner (NP).

| | | |
|---|---|---|
| Patient's Last Name | First Name | |
| Address | | |
| City | Province | Postal Code |
| ID Number | HIN | |
| Patient's Birthdate (yyyy/mm/dd) | Age | Gender ☐ M ☐ F |
| Home Phone Number | Work / Alternate Phone Number | |

Please note that **we do not see finger fractures** here in clinic. Please **send referrals to the plastic surgery department, if under 18 send to pediatric plastic surgery**.

Patient/caregiver BEST contact number:

Reason for referral:

Family aware of referral being sent? ☐ Yes ☐ No

Referring Provider Information:

Printed Name: ______________________

Signature: ______________________

Address: ______________________

Postal Code: ______________________

Telephone: ______________________

Fax: ______________________

Email (optional): ______________________

Physician Billing # ______________________

☐ Family Physician ☐ Nurse Practitioner

☐ ER Physician ☐ Specialist ____________

**If request is urgent, please contact the Orthopedic Surgeon on-call through paging:**

Brief History and/or relevant investigations attached:

Diagnostics:

Medications:

**Fax # 905-521-5069 for referrals from family physicians only**
**Fax # 905-521-5028 for referrals from Urgent Care Centers/Hospital/ERs**