University Centre
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Toronto, ON, M5G 2A2
Tel: 416-597-3422 ext: 4200
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OUTPATIENT PHYSICIAN CLINIC REFERRAL (MSK)

Patient Information	
Name:	☐ M ☐ F
Address:	
Tel (primary):	
Tel (secondary):	
Alternate Contact:	
Date of Birth (mm/dd/yyyy):	
Health Card #:	VC:
WSIB#	☐ N/A
Interpreter req'd? ☐ N ☐ Y: Language:	

Referring Physician	
Name:	
Address:	
Tel:	Fax:
Date:	Billing#
Signature:	

Referral Urgency: ☐ Routine ☐ Urgent - explain:

Refer to (name): _____

☐ Clinic to triage referral (1st available)

Suspected Diagnosis:

Estimated Date of Onset:

Requested Consultation:

- ☐ Focal MSK Issue (i.e. neck, hand, back, hip, etc…) Location: _____
- ☐ Sports Medicine
- ☐ Interventional Medicine (i.e. ultrasound guided cortisone injections)
- ☐ Pain management for subacute, focal body pain conditions < than 1 year

Treatment Goals:

- ☐ Advice to direct therapy (General MSK)
- ☐ Diagnostic clarification (General MSK)
- ☐ Interventional Procedure / Injection: Describe: _____

Past Medical History: (may be included on a separate sheet – i.e. EMR print out)

To be accepted, this application must include:

- ☐ Medication List (with allergies listed)
- ☐ Relevant Imaging Studies (X-Ray, Ultrasound, MRI, CT, etc…)
- ☐ Relevant Consultation Notes or Reports (i.e. Specialists, Physiotherapy, Occupational Therapy, etc…)