DATE:_______________

VULC REFERRAL REQUEST FORM - SHOULDER

Because of the overwhelming demand for specialist referral for shoulder, your surgeon is forced to screen consults to ensure that they are optimal for surgical referral. Accepted referrals include patients who already have had appropriate non-operative treatment such as physiotherapy and injections. Appropriate investigations such as x-ray and ultrasound or MRI should be completed prior to referral.

Referring Physician:___________________________

Billing #:_____________________________________

Address:_____________________________________

Phone Number:______________________________

Fax Number:_________________________________

Patient Name:________________________________

DOB:____

PHN:____

Contact Information:__________________________

Address:______________________________________

Referral request for: ☐**1ST SURGEON AVAILABLE** ☐**DR. THOMAS GOETZ** ☐**DR. JEFFREY PIKE** ☐**DR. PARHAM DANESHVAR**

Side: ☐**RIGHT** ☐**LEFT** ☐**BILATERAL**

Description of Patient Problem:

Imaging Information (Please indicate all available imaging):

☐XR ☐MRI ☐U/S ☐MRA ☐CT

Any images pending?: ☐XR ☐MRI ☐U/S ☐MRA ☐CT

Details (Facility/ Date of request etc.):

****(Please send imaging reports, physical films, CDs and/or nerve conduction studies to: 590-1144 Burrard St Vancouver, V6Z 2A5 – Your patient will not be booked until everything has been received.)**

Provisional Diagnosis:

Treatment Provided and Summary of Results:

Significant Patient Comorbidities:

Patient Medications: (Append sheet if list is lengthy):