SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, ON L3Y 2P9

Health Record #: _____ Complete or place barcoded patient label here

Patient Name: (Print first, last) _____

DOB: dd / mm / yy Age: _____ ❑ Female ❑ Male

OHIP #: _____ Version Code: _____

Account #: _____ Date of Admission: dd / mm / yy

Fracture Clinic Referral Form

Forms can be faxed to 905-952-3057 or emailed to fractureclinicbooking@southlake.ca

Referring Doctor: _____

_____

Discussed with Ortho on Call: ☐ Yes ☐ No

Referral From: ☐ Emergency Department

☐ Inpatient Unit _____

Reason for Referral: _____

Clinical Info:

☐ Xray Done

☐ CT Scan

☐ MRI

☐ US

☐ Other: _____

Timing of Referral:

☐ Urgent (Next Business Day)

☐ Semi-Urgent (3-5 Business Days)

☐ Routine (5 or More Days)

Surgeons

	AM	**PM**
M	Gamble	Lee
T	Tuli	Whatley
W	Nyland	Nyland
Th	Randle	Walmsley
Fr	Lindsay	Lindsay

Appointment Date: _____ **Time**: _____

Isolation Precautions:

☐ Contact ☐ Droplet/Contact ☐ Droplet ☐ Airborne ☐ Covid+

Completed by: _____ _____

FULL NAME TELEPHONE NUMBER

Please do not send patients to the clinic without an appointment.
After hours (after 1700), weekends, STAT holidays contact Bed allocation ext. 2205 for next business day appointment.

S-FRACRF