

FOOT & ANKLE CONSULTATION REQUEST

Referring Physician Form

Please complete this form and fax it to our office to begin the patient referral process.

To: Dr. Brent Haverstock

Fax: 221-8356

Patient's Name: _____

Telephone#: _____ AHC#: _____

WCB Case: Yes WCB#: _____

Referring Doctor' Stamp

Reason for Referral: _____

Past Medical History

- | | |
|--|--|
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Anti-coagulation Therapy |
| <input type="checkbox"/> Systemic Lupus Erythematosus | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Heart Mumur/Valve Replacement | <input type="checkbox"/> Pulmonary Disease |

Consultation Request

- | | |
|--|--|
| <input type="checkbox"/> Foot/Ankle Assessment | <input type="checkbox"/> Flatfoot/High Arch Foot |
| <input type="checkbox"/> Diabetic Foot Assessment | <input type="checkbox"/> Tendon Injury |
| <input type="checkbox"/> Diabetic Foot Wound/Ulcer | <input type="checkbox"/> Heel Pain |
| <input type="checkbox"/> Diabetic Foot Infection | <input type="checkbox"/> Ankle Pain/Instability |
| <input type="checkbox"/> Sports Injury Assessment | <input type="checkbox"/> Orthotic Consultation |
| <input type="checkbox"/> Structural Deformity (Bunion/Hammertoe) | <input type="checkbox"/> Surgical Consultation |

Physician's Signature

Date

FOOT & ANKLE CLINIC
AT LINDSAY PARK



www.footanklepain.ca