IWK Paediatric Orthopaedic Referral Form

FAX TO: 902 470-7237

IWK Patient ID sticker

Date of Referral:

Patient Name and Contact info

Past Medical History

Reason for Consult (Please include onset, location, duration, severity, and/or treatments)

☐ **Interpreter** Language:_____

Prior Investigations:

- ☐ Radiology report enclosed
- ☐ X-Ray
- ☐ CT
- ☐ MRI
- ☐ Bone scan
- ☐ Bloodwork
- ☐ Other: _____

Note: You may check multiple boxes. All surgeons manage trauma and general orthopaedic issues. Variations in normal alignment are assessed by our physiotherapists. If you are unsure of who to refer to, please check any surgeon.

- ☐ **Fracture clinic, discussed with Dr. _____ , to be seen within _____** Circle one **days,weeks**
- ☐ **Any Surgeon**
- ☐ **Dr. Jason Howard**: Neuromuscular conditions (cerebral palsy, spina bifida)
- ☐ **Dr. Luke Gauthier**: Neuromuscular conditions (cerebral palsy, spina bifida), Clubfoot
- ☐ **Dr. Karl Logan**: Hip Pathology (DDH, Perthes, SCFE, Labral), Tumors, Sports
- ☐ **Dr. Kevin Morash**: Scoliosis, Spinal Pathology, Limb lengthening and reconstruction
- ☐ **Dr. Ben Orlik**: Scoliosis, Spinal Pathology, Limb lengthening and reconstruction, Clubfoot
- ☐ **Nurse Practitioner Tricia Lane**: Scoliosis bracing clinic
- ☐ **Nurse Practitioner Katy van Vulpen**: Infant hip clinic
- ☐ **Physiotherapist:** Lower extremity alignment (intoeing, outtoeing, bowleg, knock knee), anterior knee pain, Femoral Anteversion, Tibial torsion, metatarsus adductus, toewalking,)

☐ **Request Travelling Clinic:** ☐ **Charlottetown** ☐ **Fredericton** ☐ **Moncton** ☐ **Sydney**

Name of Referring Physician: _____ Signature _____

https://iwkhealth.ca/clinics-programs-services/orthopaedic-clinic