Orthopaedic Cerebral Palsy Clinic

Orthopaedics: Tel: 604 875 2345 ext 3187 / Fax: 604 875 2275
www.bcchildrens.ca/orthocpclinic

Orthopaedic CP Clinic Referral Form – To be completed by referring physician
Referral will NOT be processed if incomplete

DATE OF REFERRAL

Day_____ Month_____ Year_____

PATIENT INFORMATION

Last Name: _____ Fist Name_____ DOB_____

PHN: _____ Sex: M ☐ F ☐

Address: _____

Parent/Legal guardian: _____ Relationship:_____

Phone:_____ Alternate:_____

Email:_____

Is the child in the care of the Ministry (MCFD)? Yes ☐ No ☐

If yes, SW:_____ Phone: _____

Is an interpreter needed: Yes ☐ No ☐ Language: _____

REFERRING PHYSICIAN INFORMATION

Name (PRINT): First_____ Last_____ MSP #_____

Phone:_____ Fax:_____

OTHER PHYSICIANS INVOLVED IN CARE

Family Doctor: _____ Phone: _____ Fax: _____

Pediatrician: _____ Phone: _____Fax: _____

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REASON FOR REFERRAL

Diagnosis: _____ GMFCS Level: _____

Reason for referral: _____

_____

_____

Is the child experiencing PAIN? Yes ☐ No ☐ Location:_____ Upper Extremity Involvement: Yes ☐ No ☐

OTHER SPECIALISTS/SERVICES

Service	Name of Practitioner	Service	Name of Practitioner
☐ Physiotherapist	_____	☐ Tone Management	_____
☐ Occupational Therapist	_____	☐ Other:_____	_____
☐ Neurology	_____	☐ Other:_____	_____

COMMENTS

Please attach ALL INVESTIGATIONS AND IMAGING.
Referrals will NOT be processed without supporting documentation

****ALL HIP REFERRALS MUST HAVE A RECENT A/P PELVIS XRAY****

OFFICE USE ONLY
Date Received:_____