



Acute Injury Referral

Please have all the information filled out to have the referral triaged efficiently.

Patient Demographics

First & Last Name:
Healthcare Number:
 AB Healthcare Other Province: _____
Date of Birth:
Primary Phone:
Email:
Address:

Referring Practitioner

First & Last Name:
Practitioner ID#:
Designation:
Clinic/Facility Name:
Phone:
Fax:
Address:

Referral For Sports Medicine Physician Consultation – Acute* Injury Assessment

***Acute** = the injury has occurred in the last 14 days.

Group23 **does NOT accept** medical legal cases, MVA cases, WCB cases, surgical consults, or back/neck injuries that are non-sport related

Referral To First Available
 Specific practitioner: _____

Injury Information

Initial date of injury (within the last 14 days):

Mechanism of injury:

<input type="checkbox"/> Right	<input type="checkbox"/> Left
<input type="checkbox"/> Knee	<input type="checkbox"/> Shoulder
<input type="checkbox"/> Hip	<input type="checkbox"/> Elbow
<input type="checkbox"/> Ankle	<input type="checkbox"/> Wrist
<input type="checkbox"/> Other: _____	

Diagnosis & history: _____

Previous Imaging: X-Ray MRI Ultrasound Bone Scan CT Scan

*Please attach pertinent imaging to the referral

If you do not receive a referral receipt notice within 14 days of sending the referral, please re-fax the referral. We will contact the patient once the referral is triaged via the phone number you provided.

Signature: _____

Thank you for choosing Group23 Sports Medicine

FAX to (403) 284-5656

For patient confidentiality purposes, do not email referrals.