GROUP23
SPORTS MEDICINE

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Group23.ca

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:

_____

☐ Right ☐ Left

☐ Knee ☐ Shoulder
☐ Hip ☐ Elbow
☐ Ankle ☐ Wrist
☐ 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