Providence HEALTH CARE

St. Paul's Hospital

FOOT AND ANKLE SCREENING AND TRIAGE (FAST) CLINIC
Outpatient Department
3rd Floor, Burrard Building
1081 Burrard St.,
Vancouver, B.C. V6Z 1Y6
Tel: 604-806-9691 **Fax: 604-806-8680**

REFERRAL FORM

Patient name: _____ Birth date: _____
Address: _____ Postal code: _____
Home phone number: _____ Alternate number: _____
PHN: (Care Card number) _____ ☐ MSP ☐ ICBC ☐ WCB ☐ Other
Referring physician: _____ Billing number: _____ Phone number: _____
Family physician: (if different from above) _____ FAX number: _____
Referring hospital: (if applicable) _____

REASON FOR REFERRAL ☐ Left ☐ Right

☐ Ankle pain	☐ Ankle instability	☐ Plantar fasciitis
☐ Foot pain	☐ Bunion	☐ Tendon ruptures
☐ Foot deformity	☐ Diabetic foot	☐ Tendonitis
☐ Toe deformities	☐ Other: _____	

MEDICAL HISTORY

☐ CAD	☐ MI (date) _____	☐ DVT	☐ PE	☐ COPD	☐ Sleep apnea
☐ Diabetes	☐ HIV positive	☐ Hepatitis	☐ Smoker	☐ Alcoholism	☐ Other: _____

Previous surgeries:
Allergies:
Medication List:

Referring Physician
Signature: _____ Date: _____

If available, send or fax the following information with this referral or with the patient:

1. CD ROMs / Reports: Do not send if test was done at Vancouver Coastal Hospitals *(Lion's Gate, Powell River, St. Paul's, Mount Saint Joseph, St. Mary's, Squamish, Richmond, Vancouver or UBC Hospitals).*

Test	Location	Date
X-ray (standing view of involved foot and ankle)		
CT Scan		
MRI Scan		
Bone Scan		

2. Consults: Orthopedic consult letter, Orthopedic operative report, Podiatry consult

3. Hospital Referral: Attach either Record of Admission, Discharge Summary, or Emergency Record.