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OHC
Providing rapid access hand care

Okanagan Hand Clinic (OHC) Referral Form

Fax referral to: 778-506-2029

Patient Label:

Name: _____ Referring Doctor: _____

DOB: _____ Patient phone #: _____

PHN: _____

DIAGNOSIS

Fracture:

- ☐ Phalanx Fracture ☐Prox ☐Mid ☐Distal
- ☐ Metacarpal Fracture ☐Bennett/Rolando
- ☐ Scaphoid Fracture
- ☐ Distal Radius Fracture

Soft tissue:

- ☐ Mallet Finger
- ☐ Tendon Injury ☐Flexor ☐Extensor
- ☐ Laceration/Crush Injury
- ☐ Trigger Finger
- ☐ Ganglion

Hand/Wrist Arthritis:

- ☐ CMC
- ☐ DIP/PIP
- ☐ Wrist arthritis

Peripheral Nerve:

- ☐ Carpal Tunnel Syndrome ☐ EMG complete
- ☐ Cubital Tunnel Syndrome ☐ EMG complete
- ☐ Traumatic Nerve Injury: upper or lower extremity ☐ EMG complete

Other:

CLINCAL HISTORY

Investigations to date: ☐ X-ray ☐ CT ☐ MRI // Location of imaging: _____

_____

_____

_____

_____

_____

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_____

URGENCY OF REFERRAL – for OHC office use

☐ 1 (within one week) ☐ 2 (within two weeks) ☐ 3 (within one month) ☐ 4 (within 3 months)