REFERRAL FORM

VANCOUVER HIP INSTITUTE

Date: _____

Patient Information:

Name: _____

PHN: _____

DOB: _____

Phone Number: _____

Gender: _____

Referring Physician Information:

Name: _____

MSP #: _____

WCB: _____

ICBC: _____

RCMP: _____

Reason for referral:

- ☐ Femoroacetabular Impingement
- ☐ Labral Tear
- ☐ Hamstring avulsion
- ☐ Gluteal injury/trochanteric pain syndrome
- ☐ Injection (PRP, Viscosupplementation)
- ☐ Other: _____

Imaging (Attach Reports)

X-Rays _____

CT _____

MRI _____

U/S _____

Other: _____

History:

Please Attach Past Medical History Information.

Please note: If your patient has not had the VHI series of Xrays performed at a location that is accessible to our surgeons online, your referral will be returned.

www.vancouverhipinstitute.ca **Fax: (833) 652-1552**