|  |  |  |  |
| --- | --- | --- | --- |
| Date |  | Practice | Click here to enter text. |
| Patient name | Click here to enter text. | Referring practitioner | Click here to enter text. |

I am referring this patient for a surgical opinion on;

|  |  |  |  |
| --- | --- | --- | --- |
| Choose an item. | Choose an item. | Choose an item. | Other Click here to enter text. |

Have current imaging examinations been performed?  Yes  No

(X-rays, Ultrasound C.T., MRI)

Standard X-ray views;

*A.P. & Lateral weight bearing and erect, Medial-oblique non-weight bearing*

Call 04049100054 or email rhermann@footandankle.com.au for advice on appropriate imaging if required.

|  |  |
| --- | --- |
| Medical conditions | Click here to enter text. |
| Medications | Click here to enter text. |
| Allergies | Click here to enter text. |
| Clinical history | Click here to enter text. |
| Previous treatment | Click here to enter text. |