WCB, Halifax office
5668 South Street
PO Box 1150, Halifax, NS, B3J 2Y2
Tel: 1-800-870-3331 toll free or 902-491-8999 local
Fax: 1-855-723-3975 or locally 902-491-8001

Referral Form for Centralized Surgical Services Program

IMPORTANT: CSSP consult may take 6 to 8 weeks or more. DO NOT complete this form for clinically urgent, emergent or time sensitive injuries – refer those cases to Surgeon On-Call or Emergency Department.

CLIENT INFORMATION:

Last name: | First Name: | Initial: | **WCB Claim #:**

Address: | Province: | Postal Code:

Gender: ☐ M ☐ F | Health Card #: | Family Physician Name:

Daytime Phone Number: | Evening Phone Number: | Employer name: | Date of Birth: dd mm yyyy

INJURY INFORMATION:

DATE OF INJURY: dd mm yyyy **DIAGNOSIS:** _____

MECHANISM OF INJURY: (Details: action, activity, anatomic position, lifting, twisting, force direction and impact, torsion, etc.)

_____

PLASTICS ☐ **ORTHO** ☐

SIDE ☐ Right ☐ Left ☐ Bilateral

Upper: ☐ Shoulder ☐ Elbow ☐ Hand ☐ Wrist ☐ Carpal Tunnel

Lower: ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

General ☐ Inguinal Hernia ☐ Incisional Hernia ☐ Umbilical Hernia ☐ Other: _____

Spine ☐ Cervical ☐ Thoracic ☐ Lumbar

Refer time sensitive injuries directly to Surgeon On-Call or Emergency Department

Clinical Findings: ☐ Decreased ROM ☐ Swelling ☐ Weakness/Power Loss ☐ Neurological Abnormality ☐ Gait Disturbance ☐ Abnormal SLR ☐ Abnormal/Absent Reflexes ☐ Sensory Deficit ☐ Bowel/Bladder ☐ Other: _____

Height: _____ **Weight:** _____ **Investigations** **Include copy of report** ☐ XRay ☐ CT/MRI ☐ Nerve Conduction Studies ☐ Other

Details: _____

PAST MEDICAL HISTORY:

SURGICAL: _____

MEDICAL: ☐ Diabetes ☐ Heart Disease ☐ Sleep Apnea ☐ COPD ☐ Psychiatric/Addictions ☐ Other: _____

ALLERGIES: _____

MEDICATIONS: *attach list if necessary _____

TREATMENTS already attempted for same injury: _____

If client was referred to surgeon in the past for injury to same body location, please record surgeon's name: _____

Please indicate if a CURRENT referral has already been initiated: ☐ No ☐ Yes - referral sent to: _____

REFERRING PHYSICIAN CERTIFICATION:

Signature of Physician: _____ Phone Number: _____

Physician Name: _____ Date: dd mm yyyy

Address: _____ WCB Physician # _____

*All additional pages and attachments to this Form must be annotated with the WCB Claim Number