NON-SPINE MSK CONSULTATION

Dr. Kevin Chih Kai Yang, MD, CCFP | MSP Q1849

Family Physician - Focused Musculoskeletal Care | Coquitlam, BC

REFERRAL FAX	PHONE	ONE MEDICAL CLINIC
604-937-2521	**604-937-2520**	901 Lougheed Hwy #205, Coquitlam

What I see

Region	Examples
Shoulder	Rotator cuff pain, bursitis, frozen shoulder, biceps pain, calcific tendinopathy, OA
Elbow	Tennis/golfer's elbow, distal biceps/triceps problems, persistent elbow pain
Wrist & Hand	De Quervain, trigger finger, CMC OA, carpal tunnel, tendon disorders
Hip	Greater trochanteric pain, gluteal tendinopathy, hip OA, periarticular pain
Knee	OA, effusion/swelling, patellofemoral pain, tendinopathy, pes anserine pain, Baker's cyst
Ankle & Foot	Achilles, plantar fascia, tibialis posterior/peroneal tendon problems, ankle OA

Particularly helpful referrals

✓ Diagnosis is unclear	✓ Symptoms persist despite conservative care
✓ Imaging needs clinical correlation	✓ Return-to-activity guidance is needed
✓ Aspiration or injection is being considered	✓ Ultrasound-guided treatment may be appropriate
✓ PRP / prolotherapy / injection options	

Consultation may include

Focused history and exam • imaging review • diagnostic ultrasound when appropriate • diagnosis • treatment plan • rehabilitation guidance • image-guided procedures when appropriate.

An injection is not automatically recommended. PRP and prolotherapy are uninsured services; options, alternatives and costs are reviewed with the patient when relevant.

Please do not refer for

▼ Exclusions	
• Predominantly spinal pain	• Acute fracture or major trauma
• Suspected septic joint	• Acute neurovascular compromise
• Post-operative complication needing surgeon	• Condition requiring urgent ED assessment

QUICK REFERRAL FORM

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FAX TO ONE MEDICAL CLINIC: 604-937-2521

Patient

Name: _____ PHN: _____

DOB: _____ Phone: _____

Area of concern

Side: ☐ Left ☐ Right ☐ Bilateral

Region: ☐ Shoulder ☐ Elbow ☐ Wrist/Hand ☐ Hip ☐ Knee ☐ Ankle/Foot ☐ Other: _____

Main concern: ☐ Pain ☐ Stiffness/ROM ☐ Swelling/effusion ☐ Tendinopathy ☐ Osteoarthritis

☐ Injection opinion ☐ Other: _____

Imaging (optional)

☐ None ☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ Ordered/pending ☐ Report attached

Procedure opinion (optional)

☐ None ☐ Injection opinion ☐ PRP ☐ Prolotherapy ☐ Hyaluronic acid ☐ Aspiration

Additional information (optional)

Referring clinician

Name: MSP #:

Clinic: Fax:

Signature: Date:

Your usual clinic referral letter is completely acceptable. Imaging is helpful but not required.

A consultation report and management recommendations will be returned to the referring clinician. Longitudinal primary care remains with the patient's family physician/NP.