



Patient's name – Hospital number

# Consultation form Orthopaedic surgery

Date : \_\_\_\_\_

Elective

Semi-urgent      Justification : \_\_\_\_\_

**DIAGNOSIS:**

**INVESTIGATION :**

*The patient must bring his X-Rays or a CD-ROM of his X-Rays and photocopies of relevant reports.*


**REASON FOR CONSULTATION :**

Diagnostic/Therapeutic opinion     

Referral for surgical treatment     

\_\_\_\_\_  
Name of referring physician

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
LICENSE #