SAAKIC
Southern Alberta Acute Knee Injury Clinic

Sports Medicine Centre
University of Lethbridge
PE 100, 4401 University Dr W
Lethbridge, AB T1K 3M4

Phone: 403-329-2777
Fax: 403-388-4324
Website: saakic.ca

PATIENT REFERRAL INFORMATION (please fill out completely):

Name: _____

Address: _____

Phone (H): _____ Phone (W): _____ Cell: _____

Gender: M / F Alberta Health Care #: _____

DOB: _____(MM/DD/YY) Email:_____

PHYSICIAN INFORMATION:

Referring Physician: _____

Clinic Name: _____ Practice ID #: _____

Family Physician (if different): _____

Clinic Name: _____

*NOTE: X-ray is **NOT** required prior to referral, but if available please send report. DO NOT order other imaging prior to referral (MRI, Ultrasound).*

Please check YES or NO for the following questions:

- ▫ YES ▫ NO Has the patient injured their *knee*? (Circle Left or Right)
- ▫ YES ▫ NO Did the date of injury occur within the past 6 weeks?
- ▫ YES ▫ NO Was there a sudden onset of pain at time of injury?
- ▫ YES ▫ NO Does the patient live in the South Zone boundaries?
- ▫ YES ▫ NO Was the injury caused by a motor vehicle accident?
- ▫ YES ▫ NO Did the injury happen at the workplace?

Please be informed that SAAKIC, as a consulting service, and is unable to complete insurance, disability, or work restriction forms. The patient will be referred to their family doctor for the completion of these forms based on the assessment information provided by SAAKIC.

Additional Comments (please feel free to attach a letter if you prefer):
Eg:) Date of injury, Mechanism of injury, Treatment to date, ROM, Swelling, and Stability (locking/buckling)

_____

_____

Physician's Signature:_____ Date of Referral: _____