Paediatric Acute Knee Injury Clinic

Fax: 604-875-2275

Date of referral: Patient name:

DOB (YYYY/MM/DD): PHN:

Parent / Legal Guardian: Contact #:

Interpreter required: NO YES Language:

Referring Provider: MSP#: Fax:

Criteria for Acute Knee Injury Clinic

- **traumatic knee injury within the past 6 weeks or concern of recurrent knee instability**

Date of Injury (YYYY/MM/DD):

Please Circle affected side: Right Left

Mechanism of injury: _____

Symptoms (check if present):

- ☐ Instability (knee 'gives way' or a feeling of moving out of place)
- ☐ Effusion/Hemarthrosis (ongoing or history in the context of a knee injury)
- ☐ Loss of knee motion (not being able to straighten or bend the knee completely)

Working Dx: ☐ Patellofemoral Instability ☐ ACL ☐ Meniscal tear ☐ Other

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Please include imaging reports. For MRI not completed at a hospital, please send USB/CD/etc. to Orthopaedics at BC Children's, 4480 Oak Street Vancouver BC V6H 3V4

Your patient will be seen by a team of healthcare providers and may include an orthopaedic surgeon, sports medicine physician, nurse practitioner and/or physiotherapist.