

OUTPATIENT REFERRAL TO PLASTIC SURGERY

Plastic Surgery

REASON FOR REFERRAL

Reason(s) for Referral:

☐ Trauma ☐ Skin Lesion ☐ Breast ☐ Hand/Wrist ☐ Nerve ☐ General Plastic Surgery

If TRAUMA selected

Trauma Type:

☐ Call Person on Call ☐ Hand/Wrist ☐ Burn ☐ Craniofacial ☐ Other

If SKIN LESION selected

Lesion Size (mm): _____

Location: _____

Diagnosis: _____

Pathology Confirmed? ☐ Yes ☐ No

If BREAST selected

Clinical Purpose for Surgery: ☐ Reconstruction ☐ Elective

If Reconstruction selected:

Type: ☐ Mastectomy ☐ Lumpectomy

If Elective selected:

Type: ☐ Reduction ☐ Asymmetry ☐ Other

If HAND/WRIST selected

A hand X-ray is required before referral. Has it been ordered?

☐ Yes – Hand X-ray ordered for this patient.

Type:

☐ Arthritis ☐ Dupuytren's Contracture ☐ Trigger Finger ☐ Tendon ☐ Cyst or Mass ☐ Wrist Injury/ligament tear
☐ Ulnar sided wrist pain ☐ Wrist pain ☐ Other

If NERVE selected

Type: ☐ Carpal Tunnel ☐ Cubital Tunnel ☐ Brachial Plexus ☐ Other

If GENERAL PLASTIC SURGERY selected

Describe: _____

REFERRAL TYPE & COMMENTS

Referral Type: ☐ New Referral ☐ Update to Existing Referral

Comments:
