ONTARIO ASSOCIATION OF CRANIOFACIAL TRAUMA SURGEONS (OACTS)
REFERRAL FORM

DR. REID CHAMBERS
MD FRCSC
PLASTIC AND RECONSTRUCTIVE SURGEON
PETERBOROUGH REGIONAL HEALTH CENTRE
272 CHARLOTTE STREET, SUITE 301
PETERBOROUGH, ONTARIO, K9J 2V4
PHONE: 705-876-9003
FAX: 705-874-5410

PATIENT ID STICKER

Patient's Contact Phone Number: ___________________________________

Direct referrals to Dr. Chambers should be made for non-urgent facial fractures (see list below). For any other facial fractures requiring urgent assessment or management (i.e. intra-cranial injury, airway compromise, retrobulbar hematoma, orbital muscle entrapment) please call CritiCall at **1-800-668-4357**

DATE OF REFERAL: ____/____/____ **DATE OF INJURY:** ____/____/____

REASON FOR REFERRAL: ____

DIAGNOSIS:

☐ Nasal bone fracture ☐ Zygoma fracture ☐ Orbital Fracture

☐ Maxilla fracture ☐ Mandible Fracture ☐ Frontal Sinus Fracture

☐ Other: ____

DIAGNOSTIC IMAGING PERFORMED: ☐ Plain Films ☐ CT Scan (Facial Views)

LOCATION OF IMAGING: ____

C-SPINES CLEARED: ☐ Yes ☐ No **OPHTHAMOLOGY CONSULT:** ☐ Yes ☐ No

REFERRING PHYSICIAN INFORMATION:

Name: ____ Billing #: ____________

Phone: _______________ Fax: ________________email: ________________________

Signature of Referring Physician: ____

Please Fax all referral forms to Fax number listed above and send all relevant diagnostic imaging with the patient (CT facial bones). All trauma patients should have their C-spines cleared and a referral to Ophthalmology for all orbital trauma.