

DATE OF REFERRAL: / / (dd/mm/yy)

CONSULTATION REQUEST OPTIONS (select one)

Specific hospital: KHSC, QHC, BGH, PSFDH  Next Available Surgeon  Specific Surgeon Dr. \_\_\_\_\_

PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Gender: M  F   
 Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_  
 Phone \_\_\_\_\_ Alt Phone \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ (dd/mm/yy)  
 Language if unable to speak English \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Health Card No. \_\_\_\_\_ WSIB No. \_\_\_\_\_

REFERRING PHYSICIAN - NURSE PRACTITIONER INFORMATION

Name \_\_\_\_\_ Specialty \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_ OHIP Billing No. \_\_\_\_\_  
 Signature \_\_\_\_\_

Family Physician Information (if different)

Name \_\_\_\_\_ Phone \_\_\_\_\_

REASON FOR REFERRAL

Affected Joint(s):  Hip  R  L  Bilateral  Knee  R  L  Bilateral  
 Diagnosis:  Osteoarthritis  Inflammatory Arthritis  Other: \_\_\_\_\_  
 Type:  Primary Joint Replacement  Revision Joint Replacement  Management Advice/Opinion  
 Urgency of Referral:  URGENT  Routine Patient would consider replacement surgery? \_\_\_ Yes \_\_\_ No

X-RAY REPORT (must accompany referral) \* Patient must bring film to appointment if not done at hospital

X-Ray Requirements: Knee: Standing AP, Lateral (flexed @ 30°), and skyline views of affected knee(s) **MRI is not appropriate**  
 (must be within last 6 months) Hip: AP pelvis (centred at pubis), and AP and Lateral of affected hip(s)

CLINICAL INFORMATION

Current Symptoms (check all that apply)

Locking  Instability/giving way  Swelling  
 Pain with activity:  Mild  Moderate  Severe  
 Pain at rest/night:  Mild  Moderate  Severe

Current Assistive Devices

None  Cane(s)  Crutches  
 Rollator/Walker  Wheelchair  Bedridden

PREVIOUS/CURRENT TREATMENTS

Physio/Occupational Therapy  NSAID/COXIB  Opioids  Steroid Injection  
 Analgesics/Acetaminophen  Weight loss  Arthroscopy  Viscosupplemental Injection  
 Other \_\_\_\_\_

CO-MORBIDITIES, MEDICATIONS & ALLERGIES (please list or attach cumulative patient profile)

\_\_\_\_\_  
 \_\_\_\_\_

FOR CENTRAL INTAKE AND ASSESSMENT CENTRE USE ONLY

Triage Code: \_\_\_\_\_ Triaged by: \_\_\_\_\_