SE LHIN Hip and Knee Arthritis Referral Form

FAX TO: 613-549-8382 **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 this referral) MRI IS NOT APPROPRIATE

X-Ray Requirements:
(must be within last 6 months)

Knee: Bilateral Standing AP, Lateral (flexed @ 30°), and skyline views

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 _____ ☐ Bracing

PLEASE ATTACH CUMMULATIVE PATIENT PROFILE (patient history) AND CO-MORBIDITIES, MEDICATIONS & ALLERGIES