Regional Arthritis Hip and Knee Replacement Program

☐ **Preferred Surgeon: Dr.**
☐ **Kingston Health Sciences Centre**
☐ **Brockville General Hospital**
☐ **First available surgeon (anywhere in the LHIN)**
☐ **Quinte Health Care - Belleville**
☐ **Perth/Smiths Falls District Hospital**

REQUEST FOR CONSULTATION FAX: 613-549-8382

REFERRAL DATE (YYYY/MM/DD): _____

***INCOMPLETE REFERRALS WILL BE RETURNED**

PLEASE ATTACH CUMULATIVE PATIENT PROFILE (patient history) AND CO-MORBIDITIES/MEDICATIONS

Referring Physician Information – may use stamp

Name: _____
Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____
Billing #: _____
CPSO/CNO #: _____

Signature: _____

Family Physician Information (if different)
Name: _____
Phone: _____

Patient Information – may use sticker

Name: _____
Address: _____
_____
Phone: _____
Email: _____
Date of Birth: _____
Health Card #: _____
Gender: ☐ Male ☐ Female ☐ Nonbinary
Language Preferred: ☐ English ☐ French Other: _____
Height: cm/inches Weight: kg/lbs

Alternate Contact Information:
_____
_____

Clinical Information

Diagnosis:

Hip: Right Left Bilateral
Knee: Right Left Bilateral

☐ Osteoarthritis
☐ Inflammatory Arthritis
☐ Other (specify): _____

Type : ☐ Primary Joint Replacement
☐ Management Advice Opinion

Current Assistive Devices

☐ NONE ☐ Rollator/ Walker
☐ Cane(s) ☐ Wheelchair
☐ Crutches

Current Symptoms (check all that apply) :

☐ NONE
☐ Locking
☐ Instability/ giving away
☐ Swelling
☐ Pain with activity: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain at rest/ night: ☐ Mild ☐ Moderate ☐ Severe
☐ Other (Specify): _____

Urgency of Referral: ☐ URGENT ☐ Routine

Does the patient want surgery? ☐ Yes ☐ No

Treatment to Date

☐ None
☐ NSAIDS/COXIB
☐ Opioids
☐ Analgesics/Acetaminophen
☐ Cortisone injections
☐ Visco injections
☐ Physio/Occ Therapy
☐ GLA:D
☐ Arthritis Society
☐ Weight Loss
☐ Exercise
☐ Bracing
☐ Other:

Diagnostic Imaging Required:

This referral MUST be accompanied by the imaging report; otherwise IT WILL BE RETURNED.

In the setting of Moderate to Severe Arthritis an MRI and Ultrasound are not required.

We REQUIRE the following specific X-rays, completed within the last six (6) months:

Hip:

1. **AP pelvis**
2. **Lateral of affected hip**

Knee: including BILATERAL WEIGHT-BEARING views
(please note that "routine" views of the knee ARE NOT weight-bearing)

1. **weight bearing AP**
2. **lateral flexed at 30°**
3. **skyline view**