Request for Orthopaedic Consultation

Knee and Hip Arthritis Management

Referral Date: YYYY | MM | DD

FAX: (855) 346-9138 All information above the double line must be complete.

CONSULTATION OPTIONS

❒ **Preferred Hospital** (select one)

- ☐ Humber River Hospital
- ☐ Mackenzie Health
- ☐ Markham Stouffville Hospital
- ☐ North York General Hospital
- ☐ Southlake Regional Health Centre

❒ **Preferred Surgeon, Dr.** ______________________ or ❒ First Available Surgeon

Referring Physician Information

Name: ______________________
Specialty: ______________________
Address: ______________________
____
Phone: ______________________
Fax: ______________________
Email: ______________________
Billing #: ______________________
Signature: ______________________

Family Physician Information (if different)

Name: ______________________
Phone: ______________________

Patient Information

Name: ______________________
Address: ______________________
____
Date of Birth: ______________________
Health Card #: ______________________ VC: _____

Gender: ☐ Male ☐ Female
Language if unable to speak English:
____
Phone: ______________________
Alternate Phone: ______________________
Email: ______________________

DIAGNOSIS:

☐ Osteoarthritis ☐ Inflammatory arthritis
☐ Post-traumatic arthritis ☐ Other:
____

REASON FOR REFERRAL:

☐ Primary Replacement:
☐ Hip Right / Left ☐ Knee Right / Left
URGENCY: ☐ Routine ☐ Urgent

X-RAY REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL

If no X-ray report is available from within the last 12 months, we recommend the following views:
Knee: AP weight bearing, lateral of knee flexed at 30°, skyline
Hip: AP Pelvis, AP of affected hip and cross table lateral
Patients are required to bring their X-Rays to their appointment.
In the setting of osteoarthritis, MRI is not recommended.

CURRENT SYMPTOMS (check all that apply)

☐ Pain with activity: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain at rest/night: ☐ Mild ☐ Moderate ☐ Severe
☐ Other: ______________________

TREATMENTS TO DATE (check all that apply)

☐ Analgesics ☐ Non-steroidal anti-inflammatory drugs
☐ Injections: ☐ Steroid ☐ Viscosupplement
☐ Arthroscopy ☐ Physiotherapy
☐ Exercise/weight loss ☐ Other: ______________________

CURRENT ASSISTIVE DEVICES

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

MEDICATIONS & MEDICAL HISTORY
(please attach patient profile)

Has there been a recent significant change in function (e.g., threat to independence), pain level and/or range of motion? Are there systemic signs (e.g., fever, chills)? Other significant issues?

Please forward any additional information that will assist us in determining urgency

COMPLETION OF THIS FORM WILL EXPEDITE YOUR REQUEST