Ontario
Central East Local Health Integration Network
Réseau local d'intégration des services de santé du Centre-Est

Request for Orthopaedic Consultation
Hip and Knee Arthritis Management

Referral Date: YYYY	MM	DD
Referral Tracking Number:		

FAX: 1-833-222-9065 All information above the double line must be complete.

CONSULTATION OPTIONS (select **ONE** or referral will be processed as "closest to home")

❒ **First available assessment**

❒ **First available surgeon** ❒ **Preferred Surgeon: Dr.** _____Name_____ ____Organization____

❒ **Preferred Hospital (*select one or more locations below*)**

- ☐ Hospital closest to home
- ☐ Peterborough Regional Health Centre (***select site***)
  - ☐ Peterborough site ☐ Haliburton satellite (**OTN**)
- ☐ Scarborough Health Network (***select site***)
  - ☐ General site ☐ Centenary site
- ☐ Other hospital:_____
- ☐ Ross Memorial Hospital (***select site***)
  - ☐ Lindsay site ☐ Haliburton satellite (**OTN**)
- ☐ Lakeridge Health (***select site***)
  - ☐ Oshawa Hospital ☐ Ajax-Pickering Hospital

Referring Primary Care Provider Information

Name: _____
Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____
Billing #: _____
Signature: _____

Family Physician Information (if different)

Name: _____
Phone: _____

Patient Information

Name: _____
Address: _____
Postal Code: _____ City: _____
Date of Birth: _____
Health Card #: _____ VC: ____
WSIB Claim #: _____
Sex: _____
Official Language preferred: ☐ French ☐ English
Other language _____
Phone: _____
Alternate Phone: _____
Email: _____

DIAGNOSIS: ☐ **Hip:** ☐ R / ☐ L ☐ **Knee:** ☐ R / ☐ L

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

REASON FOR REFERRAL:

- ☐ Primary Replacement: ☐ Hip ☐ Knee
- ☐ Opinion/management advice: ☐ Hip ☐ Knee

☐ **Patient will bring a CD of their X-Ray to appointment (required)**

X-RAY REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL

If no X-ray report is available from within the last 6 months, we recommend the following views:
Knee: AP weight bearing/standing, lateral of knee flexed at 30°, skyline, bilateral PA flexed at 30°

Hip: AP pelvis, AP and lateral of affected hip
In the setting of osteoarthritis, MRI and Ultrasound are not required.

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CURRENT SYMPTOMS (check all that apply)	**TREATMENTS TO DATE** (check all that apply)
☐ Locking ☐ Instability/giving way ☐ Swelling ☐ Pain with activity: ☐ Mild ☐ Moderate ☐ Severe ☐ Pain at rest/night: ☐ Mild ☐ Moderate ☐ Severe ☐ Other: _____	☐ 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 ☐ Bedridden	**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

For use by Central Intake

Referral Tracking Number (RTN): MRN#:

Reviewed by: Date:

Date updated: 2019-03-26

Central Intake Telephone: 1-800-263-3877 x 2828

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