Thunder Bay Regional Health Sciences Centre

Riverside Health Care

DRHC Dryden Regional Health Centre

Lake of the Woods District Hospital

Regional Joint Assessment Centre

HIP AND KNEE REFERRAL FORM

Place Patient Label with Barcode Here

Guidelines:
1. Referring Physician to complete referral form.
2. Referral is to be faxed to the Regional Joint Assessment Centre at 1-844-497-2445
3. The Regional Joint Assessment Center clerk will receive the referral form and book the patient's appointment.
4. Completed referrals will be filed in the Regional Joint Assessment Centre on the patient's health record.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Gender ☐ Male ☐ Female

Health Card Number: _____ Date of Birth: _____
Day Month Year

Address: _____ City: _____ Postal Code: _____

Phone Number: ( ) _____ Alternate Phone Number: ( ) _____ ☐ WSIB Claim No.

REASON FOR REFERRAL

Type: ☐ Primary Joint Replacement ☐ Revision Joint Replacement ☐ Opinion/management advice

Diagnosis: ☐ Osteoarthritis ☐ Inflammatory Arthritis ☐ Other _____

Affected Joint(s): ☐ HIP ☐ Right ☐ Left ☐ Bilateral ☐ KNEE ☐ Right ☐ Left ☐ Bilateral

Level of Pain: ☐ mild ☐ moderate ☐ severe Functional Limitation: ☐ mild ☐ moderate ☐ severe

* X-RAY REPORT (must be within the last 3 months) * Send x-ray report with referral. * Patient to bring films.

X-ray Requirements (AP - Anterior Posterior)

Knee: Independent weight bearing AP lateral Skyline single leg. Weight bearing AP standing view, lateral and Skyline bilateral legs

Hip: AP pelvis centred at pubis, AP and Lateral of proximal half of affected femur

Note: In the setting of Osteoarthritis, MRI is not usually contributory and is not recommended

PREVIOUS JOINT SURGERY	DATE OF SURGERY	NAME OF SURGEON

TREATMENT TO DATE

☐ Weight Loss ☐ Steroid Injection ☐ Acetaminophen ☐ Physical Therapy

☐ Cane / Walker ☐ NSAID / COXIB ☐ Opiods ☐ Other _____

NSAID - Non-steroidal anti-inflammatory / COXIB - Celecoxib nhibitor

CO-MORBIDITIES, MEDICATIONS AND ALLERGIES (please attach cumulative patient profile)

Has there been a significant change in function or pain level? _____

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

SURGEON / HOSPITAL OPTIONS

☐ First Available Date / Surgeon ☐ Preferred Surgeon _____ ☐ Preferred Site

REFERRING PHYSICIAN INFORMATION

Last Name: _____ **First Name:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Phone Number: ( ) _____ **Fax Number: ( )** _____

Referring Physician Signature: _____ **Physician Referral Number:** _____

Date: (Day/Month/Year)

Name of Primary Care Provider (if different)

Phone and Fax number

REGIONAL JOINT ASSESSMENT CENTRE USE ONLY:

TREFRJACHK