# 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. KOO** 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**