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. WATTS** ________ 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