Request for Orthopaedic Consultation

Knee and Hip Arthritis Management

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 6 months, we recommend the following views:
Knee: AP weight bearing, lateral of knee flexed at 30°, skyline | **Hip**: AP pelvis, AP and lateral of affected hip

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