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. SHIRALI** 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