

Hip and Knee Arthritis Program

Toronto Central LHIN Joint Health and Disease Management Program

REQUEST FOR ORTHOPAEDIC CONSULTATION

Referral Date:	YYYY	MM	DD
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CONSULTATION REQUESTED FROM: (select one)

Note: if no selection is made, referral will be processed as "next available".

- Next available appointment within Toronto Central LHIN – FAX to (416) 599-4577
Toll Free: 1-877-411-4577**
- Hospital (select hospital and fax to identified number):**
 - Holland Orthopaedic & Arthritic Centre (Fax 416-599-4577)
 - Mount Sinai Hospital (Fax: 416-586-8673)
 - St. Michael's Hospital (Fax: 416-864-5817)
 - Michael Garron Hospital (Fax: 416-469-6145)
 - St. Joseph's Health Centre (Fax: 416-530-6032)
 - Toronto Western Hospital (Fax: 416-603-5765)
- Dr.** _____ (identify orthopaedic surgeon and fax to hospital using fax numbers above)

Physician Information	Referring Physician Information Name: _____ Specialty: _____ Address: _____ Phone: _____ Fax: _____ Email: _____ Billing #: _____ Signature: _____ Family Physician Information (if different) Name: _____ Phone: _____	Name: _____ Address: _____ Date of Birth: _____ Health Card #: _____ VC: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Language if unable to speak English: _____ Phone (Home): _____ Phone (Work): _____ Phone (Cell): _____ Email: _____ WSIB #: _____	Patient Information
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DIAGNOSIS: <input type="checkbox"/> Hip Right / Left <input type="checkbox"/> Knee Right / Left <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Inflammatory arthritis <input type="checkbox"/> Fracture <input type="checkbox"/> Post-traumatic arthritis <input type="checkbox"/> Failed hip or knee replacement <input type="checkbox"/> Joint derangement not yet diagnosed <input type="checkbox"/> Other: _____	CONSIDERATION FOR: <input type="checkbox"/> Primary Replacement: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Opinion on <u>prior</u> replacement: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Opinion Requested: <input type="checkbox"/> Hip <input type="checkbox"/> Knee URGENCY: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent
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PLEASE ATTACH EXISTING X-RAY REPORTS OF THE AFFECTED JOINT

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

Clinical Information	CURRENT SYMPTOMS (check all that apply) <input type="checkbox"/> Locking <input type="checkbox"/> Instability/giving way <input type="checkbox"/> Swelling <input type="checkbox"/> Pain with activity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Pain at rest/night: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Other: _____	TREATMENTS TO DATE (check all that apply) <input type="checkbox"/> Analgesics <input type="checkbox"/> Non-steroidal anti-inflammatory drugs <input type="checkbox"/> Injections: <input type="checkbox"/> Steroid <input type="checkbox"/> Viscosupplement <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Exercise/weight loss <input type="checkbox"/> Other: _____
	CURRENT ASSISTIVE DEVICES <input type="checkbox"/> None <input type="checkbox"/> Cane(s) <input type="checkbox"/> Crutches <input type="checkbox"/> Rollator/Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden	CURRENT MEDICATIONS (please list or attach medication 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

CI USE ONLY	TC Ref. ID# :	MRN#:
	Triage Code: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G	Triaged by: _____ Date: _____

Please note that **all areas ABOVE the double line MUST be completed**