Ontario Health atHome

Request for Orthopaedic Consultation
Hip and Knee Arthritis Management

Referral Date: YYYY | MM | DD

FOR CENTRAL INTAKE USE ONLY
Referral Tracking Number (RTN): _____
Processed by: Initials YYYY MM DD

FAX: 1-833-222-9065
All information above the double line must be complete.

CONSULTATION OPTIONS (please select **one** option only)

- ❒ **Preferred Surgeon: Dr.** __Name__ _____ __ Organization__
- ❒ **First available surgeon** (anywhere in the LHIN)
- ❒ **First available assessment/hospital** (anywhere within the LHIN, which may not be closest to the patient's home)
- ❒ **Peterborough Regional Health Centre (*select site*)**
  - ☐ Peterborough site ☐ Haliburton satellite (OTN)
- ❒ **Ross Memorial Hospital (*select site*)**
  - ☐ Lindsay site ☐ Haliburton satellite (OTN)
- ❒ **Scarborough Health Network (*select site*)**
  - ☐ General site ☐ Centenary site
- ❒ **Lakeridge Health (*select site*)**
  - ☐ Oshawa Hospital ☐ Ajax-Pickering Hospital
- ❒ **Hospital closest to home**
- ❒ **Other hospital:** _____

Referring Primary Care Provider Information

Name: _____
Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____
Billing #: _____
Signature: _____

Family Physician Information (if different)

Name: _____
Phone: _____

Patient Information

Name: _____
Address: _____
Postal Code: _____ City: _____
Date of Birth: _____
Health Card #: _____ VC: ____

Sex: _____
Official Language preferred: ☐ French ☐ English
Other language _____
Phone: _____
Alternate Phone: _____

DIAGNOSIS: ☐ **Hip:** ☐ R / ☐ L ☐ **Knee:** ☐ R / ☐ L

☐ Osteoarthritis ☐ Inflammatory arthritis
☐ Post-traumatic arthritis ☐ Other: _____

REASON FOR REFERRAL:

☐ Primary Replacement: ☐ Hip ☐ Knee
☐ Opinion/management advice: ☐ Hip ☐ Knee

X-RAY CONDUCTED WITHIN 6 MONTHS IS REQUIRED FOR REFERRAL – SEE BELOW FOR VIEWS

☐ Patient will bring a CD or digital download of their X-Ray to appointment

Knee: AP weight bearing/standing, lateral of knee flexed at 30°, skyline, bilateral PA flexed at 30°
Hip: AP pelvis, AP and lateral of affected hip
In the setting of osteoarthritis, MRI and Ultrasound are not required.

CURRENT SYMPTOMS (check all that apply)

☐ Locking ☐ Instability/giving way ☐ Swelling
☐ 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 ☐ Bedridden

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

SHN Scarborough Health Network | Lakeridge Health | PRHC Peterborough Regional Health Centre | Ross Memorial Hospital Kawartha Lakes | Haliburton Highlands Health Services