



Request for Orthopaedic Consultation

Knee and Hip Arthritis Management

FAX: (855) 346-9138 All information above the double line must be complete.	
CONSULTATION OPTIONS <input type="checkbox"/> Preferred Hospital (select one) <input type="checkbox"/> Humber River Hospital <input type="checkbox"/> Mackenzie Health <input type="checkbox"/> Markham Stouffville Hospital <input type="checkbox"/> North York General Hospital <input type="checkbox"/> Southlake Health <input type="checkbox"/> Preferred Surgeon, Dr. _____ or <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female Language if unable to speak English: _____ Phone: _____ Alternate Phone: _____ Email: _____
DIAGNOSIS: <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Inflammatory arthritis <input type="checkbox"/> Post-traumatic arthritis <input type="checkbox"/> Other: _____	REASON FOR REFERRAL: <input type="checkbox"/> Primary Replacement: <input type="checkbox"/> Hip Right / Left <input type="checkbox"/> Knee Right / Left URGENCY: <input type="checkbox"/> Routine <input type="checkbox"/> 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) <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	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	