tjac
TOTAL JOINT ASSESSMENT CENTRE

☐ CENTRAL SITE
North York General Hospital – Branson Site
555 Finch Avenue West, Toronto, Ontario M2R 1N5
TEL 416-635-2415 **FAX 416-635-2427**

☒ SATELLITE SITE
Markham Stouffville Hospital
381 Church Street, Markham, Ontario L3P 7P3

PATIENT INFORMATION

Last Name _____ First Name _____ Gender: M ☐ F ☐

Address _____

City _____ Postal Code _____

Phone No. _____ Alt. Phone No. _____

Health Card No. _____ Date of Birth ____ / ____ / ____ (DD / MM / YY)

[PATIENT STICKER]

REASON FOR REFERRAL

Diagnosis ☐ Osteoarthritis ☐ Inflammatory Arthritis ☐ Other

Type ☐ Primary Joint replacement ☐ Revision Joint Replacement

Affected Joint(s) ☐ **Hip** ☐ R ☐ L ☐ Bilateral ☐ **Knee** ☐ R ☐ L ☐ Bilateral

Level of Pain ☐ mild ☐ moderate ☐ severe

Functional Limitation ☐ mild ☐ moderate ☐ severe

X-Ray Report

Knee: Lateral, Skyline, and AP standing

Hip: AP pelvis, Lateral proximal femur

Fax x-ray reports along with Referral Form

SURGEON / HOSPITAL OPTIONS

Preferred Surgeon: ☐ First Available Date / First Available Surgeon ☒ Preferred surgeon Dr. Hemant Shirali

Preferred Hospital: ☒ Markham Stouffville Hospital ☐ North York General Hospital

REFERRING PHYSICIAN'S INFORMATION

Last Name: _____ First Name: _____

Address _____

City _____ Postal Code _____

Phone No. _____ Fax No. _____

OHIP Billing No _____

Referring Physician's Signature: _____

[PHYSICIAN'S STICKER/STAMP]

TOTAL JOINT ASSESSMENT CENTRE USE ONLY

Assessment Centre Candidate Y ☐ N ☐

Clinician's Signature: _____ Date: ____ / ____ / ____ (DD / MM / YY)