



# Request for Orthopaedic Consultation

## Knee and Hip Arthritis Management

**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.** \_\_\_\_\_ 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 6 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**