

ORTHOPAEDIC HIP & KNEE ARTHRITIS PROGRAM
RAPID ACCESS CLINIC REFERRAL FORM
TEL: (416) 469-6580 x.6161 FAX: (416) 469-6145

Patient ID Label



Routine Urgent

Patient Last Name:		Given Name:		<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: (DD / MMM / YYYY)
Address:			Apt#:		Telephone Number – Primary Number: ()
Town or City:		Province:	Postal Code:		Telephone Number – Secondary Number: ()
Emergency Contact:			Relationship To Patient:		Telephone Number – Emergency Contact: ()
Family Physician:		Ontario Health Card Number: Version Code		Email Address For Virtual Consult:	
Height (cm):	Weight (kgs):	Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown			

Required Questions:	PRIVACY: If we call the patient, can we leave a voice message? <input type="checkbox"/> No <input type="checkbox"/> Yes
	WSIB: Is this treatment due to a work related injury? <input type="checkbox"/> No <input type="checkbox"/> Yes Claim Number:
	American Sign Language interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Language interpreter required? - specify: <input type="checkbox"/> No <input type="checkbox"/> Yes

Referred To:	<input type="checkbox"/> First Available Appointment	<input type="checkbox"/> Dr. Catre	<input type="checkbox"/> Dr. Chang	<input type="checkbox"/> Dr. Higgins	Referral Date:
		<input type="checkbox"/> Dr. Tsvetkov	<input type="checkbox"/> Dr. Wong		

<p>IMPORTANT: Please attach existing X-Ray reports of the affected joint</p> <p>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.</p>	Reason For Referral:	<input type="checkbox"/> Primary Replacement <input type="checkbox"/> Opinion on Prior Replacement <input type="checkbox"/> Management Advice/Opinion <input type="checkbox"/> Second Opinion	<input type="checkbox"/> Hip - Right <input type="checkbox"/> Hip - Left <input type="checkbox"/> Knee - Right <input type="checkbox"/> Knee - Left
	Investigations To Date:	<input type="checkbox"/> X-ray <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Ultrasound <input type="checkbox"/> Lab Tests <input type="checkbox"/> Procedures Notes <input type="checkbox"/> Consultation Notes <input type="checkbox"/> Other Tests:	
	Current Problem:	<input type="checkbox"/> None <input type="checkbox"/> Locking <input type="checkbox"/> Instability/Giving Way <input type="checkbox"/> Swelling <input type="checkbox"/> Pain with Activity <input type="checkbox"/> Pain at Rest/Night <input type="checkbox"/> Other:	
	Treatments To Date:	<input type="checkbox"/> None <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Analgesics (topical and oral) <input type="checkbox"/> Bracing <input type="checkbox"/> Exercise/Weight Loss <input type="checkbox"/> Injection(s) <input type="checkbox"/> Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) <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	
	Past Medical History:	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Inflammatory Arthritis <input type="checkbox"/> Post-Traumatic Arthritis <input type="checkbox"/> Fracture <input type="checkbox"/> Failed Replacement <input type="checkbox"/> Joint Derangement Not Yet Diagnosed <input type="checkbox"/> Other:	
	Medications:		

Referring Physician:	Physician Name:	
	Telephone Number: ()	Fax Number: ()
	Physician's Signature:	
	Billing#:	



Ocean eServices Program
We now accept Ocean eReferrals for various clinics. The best way to find Specialist and refer your patients. For more information and to sign-up for your Ocean user account, contact Ontario eHealth at eReferral@ehealthce.ca

Appointment Information:		RTS TC Reference ID:	
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