MICHAEL GARRON HOSPITAL
TORONTO EAST HEALTH NETWORK

Proud member of
East Toronto Health Partners

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

REF

☐ **Routine** ☐ **Urgent**

Patient ID Label

Patient Last Name:	Given Name:	☐ M ☐ F	Date of Birth: (DD / MMM / YYYY)
Address:	Apt#:		Telephone Number – Primary Number: ( )
Town or City:	Province:	Postal Code:	Telephone Number – Work Number: ( )
Contact Person (Caregiver/Parent/Guardian):	Relationship To Patient:		Telephone Number - Contact Person: ( )
Family Physician:	**Ontario Health Card Number:** Version Code		**Email Address For Virtual Consult:**

Height (cm):	Weight (kgs):	Allergies: ☐No ☐Yes ☐Unknown

Required Questions:

PRIVACY: If we call the patient, can we leave a voice message? ☐No ☐Yes
WSIB: Is this treatment due to a work related injury? ☐No ☐Yes Claim Number:
American Sign Language interpreter required? ☐No ☐Yes
Language interpreter required? - specify: ☐No ☐Yes

Referred To:

☐ **First Available Appointment** ☐ Dr. Catre ☐ Dr. Chang
☐ Dr. Higgins ☐ Dr. Kraemer ☐ Dr. Tsvetkov ☐ Dr. Weiler ☐ Dr. Wong

Referral Date:

IMPORTANT:
Please attach existing X-Ray reports of the affected joint

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.

Reason For Referral:
☐ Primary Replacement
☐ Opinion on Prior Replacement
☐ Management Advice/Opinion
☐ Second Opinion
☐ Hip - Right
☐ Hip - Left
☐ Knee - Right
☐ Knee - Left

Investigations To Date: ☐ X-ray ☐ CT ☐ MRI ☐ Ultrasound ☐ Lab Tests ☐ Procedures Notes ☐ Consultation Notes ☐ Other Tests:

Current Problem: ☐ None ☐ Locking ☐ Instability/Giving Way ☐ Swelling ☐ Pain with Activity ☐ Pain at Rest/Night ☐ Other:

Treatments To Date: ☐ None ☐ Physiotherapy ☐ Arthroscopy ☐ Analgesics (topical and oral) ☐ Bracing ☐ Exercise/Weight Loss ☐ Injection(s) ☐ Non-Steroidal Anti-Inflammatory Drugs (NSAIDS) ☐ Other:

Current Assistive Devices: ☐ None ☐ Cane(s) ☐ Crutches ☐ Rollator/Walker ☐ Bedridden

Past Medical History: ☐ Osteoarthritis ☐ Inflammatory Arthritis ☐ Post-Traumatic Arthritis ☐ Fracture ☐ Failed Replacement ☐ Joint Derangement Not Yet Diagnosed ☐ Other:

Medications:

Referring Physician:

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

Appointment Information:

RTS TC Reference ID:

Ocean by CognisantMD — Ontario 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**