Hip and Knee Arthritis Program

Toronto Central LHIN Joint Health and Disease Management Program

REQUEST FOR ORTHOPAEDIC CONSULTATION

Referral Date:	YYYY	MM	DD

CONSULTATION REQUESTED FROM: (select one)
Note: if no selection is made, referral will be processed as "next available".

❐ **Next available appointment within Toronto Central LHIN – FAX to (416) 599-4577**
Toll Free: 1-877-411-4577

❐ **Hospital (select hospital and fax to identified number):**

- ☐ Holland Orthopaedic & Arthritic Centre (Fax 416-599-4577)
- ☐ Mount Sinai Hospital (Fax: 416-586-8673
- ☐ St. Michael's Hospital (Fax: 416-864-5817)
- ☐ Michael Garron Hospital (Fax: 416-469-6145)
- ☐ St. Joseph's Health Centre (Fax: 416-530-6032)
- ☐ Toronto Western Hospital (Fax: 416-603-5765)

❐ **Dr.** ______________________________ (identify orthopaedic surgeon and fax to hospital using fax numbers above)

Physician Information

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 (Home): ______________________________
Phone (Work): ______________________________
Phone (Cell): ______________________________
Email: ______________________________
WSIB #: ______________________________

Clinical Information

DIAGNOSIS: ☐ Hip Right / Left ☐ Knee Right / Left

☐ Osteoarthritis ☐ Inflammatory arthritis ☐ Fracture
☐ Post-traumatic arthritis ☐ Failed hip or knee replacement
☐ Joint derangement not yet diagnosed
☐ Other: ______________________________

CONSIDERATION FOR:

☐ Primary Replacement: ☐ Hip ☐ Knee
☐ Opinion on prior replacement: ☐ Hip ☐ Knee
☐ Opinion Requested: ☐ Hip ☐ Knee
URGENCY: ☐ Routine ☐ Urgent

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

CURRENT SYMPTOMS (check all that apply)

☐ Locking ☐ Instability/giving way ☐ Swelling
☐ 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 ☐ Bedridden

CURRENT MEDICATIONS (please list or attach medication 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

CI USE ONLY

TC Ref. ID# :		MRN#:	

Triage Code: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ G Triaged by: __________________ Date: ________________

Please note that **all areas ABOVE the double line MUST be completed**

Rev: May 2017