Ontario Health atHome

# Request for Orthopaedic Consultation
## Hip and Knee Arthritis Management

| Referral Date: YYYY | MM | DD |
|---|---|---|

**FOR CENTRAL INTAKE USE ONLY**
**Referral Tracking Number (RTN):** ____________________
Processed by: Initials YYYY MM DD

**FAX: 1-833-222-9065**
**All information above the double line must be complete.**

**CONSULTATION OPTIONS** (please select **one** option only)

❐ **Preferred Surgeon: Dr.** __Name__ ___ Organization__
❐ **First available surgeon** (anywhere in the LHIN)
❐ **First available assessment/hospital** (anywhere within the LHIN, which may not be closest to the patient's home)
❐ **Peterborough Regional Health Centre (*select site*)**
- ☐ Peterborough site ☐ Haliburton satellite (OTN)

❐ **Ross Memorial Hospital (*select site*)**
- ☐ Lindsay site ☐ Haliburton satellite (OTN)

❐ **Scarborough Health Network (*select site*)**
- ☐ General site ☐ Centenary site

❐ **Lakeridge Health (*select site*)**
- ☐ Oshawa Hospital ☐ Ajax-Pickering Hospital

❐ **Hospital closest to home**
❐ **Other hospital:** ____________________

**Referring Primary Care Provider Information**

Name: ____________________
Specialty: ____________________
Address: ____________________
____________________
Phone: ____________________
Fax: ____________________
Billing #: ____________________
Signature: ____________________

**Family Physician Information** (if different)

Name: ____________________
Phone: ____________________

**Patient Information**

Name: ____________________
Address: ____________________
Postal Code: __________ City: ____________________
Date of Birth: ____________________
Health Card #: ____________________ VC: _____

Sex: ____________________
Official Language preferred: ☐ French ☐ English
Other language ____________________
Phone: ____________________
Alternate Phone: ____________________

**DIAGNOSIS:** ☐ **Hip:** ☐ R / ☐ L ☐ **Knee:** ☐ R / ☐ L
☐ Osteoarthritis ☐ Inflammatory arthritis
☐ Post-traumatic arthritis ☐ Other: ____________________

**REASON FOR REFERRAL:**
☐ Primary Replacement: ☐ Hip ☐ Knee
☐ Opinion/management advice: ☐ Hip ☐ Knee

**X-RAY CONDUCTED WITHIN 6 MONTHS IS REQUIRED FOR REFERRAL – SEE BELOW FOR VIEWS**
☐ Patient will bring a CD or digital download of their X-Ray to appointment

**Knee**: AP weight bearing/standing, lateral of knee flexed at 30°, skyline, bilateral PA flexed at 30°
**Hip**: AP pelvis, AP and lateral of affected hip
**In the setting of osteoarthritis, MRI and Ultrasound are not required.**

**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

**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**



SHN Scarborough Health Network | Lakeridge Health | PRHC Peterborough Regional Health Centre | Ross Memorial Hospital Kawartha Lakes | Haliburton Highlands Health Services — Leaders in Innovative Rural Health Care