SCOPE

SEAMLESS CARE
OPTIMIZING THE PATIENT EXPERIENCE

Building Connections between Primary and Specialty Care

November 26th| 5:30 – 8:00 pm
Toronto General Hospital
Astellas Conference Room

2 Mainpro+ Credits

HealthLink Mid West Toronto Let's Make Healthy Change Happen

WCHH Women's College Hospital Health care for women: REVOLUTIONIZED

UHN

CCAC CASC Community Care Access Centre

Mount Sinai Hospital Joseph and Wolf Lebovic Health Complex

Agenda

5:30 – 5:45	**Dinner and Networking**
5:45 – 5:50	**Welcome and Introductions** **Dr. Pauline Pariser** - Clinical Lead, Mid-West Sub-Region
5:50 – 6:25	**Panel on Maximizing the Use of eConsult** **eConsult Stats –** Ian McMillan **Nephrology –** Stephanie Ong **Hematology –** Dr. Jean Wang **Primary Care –** Dr. Rui Martins
6:25 – 6:45	**Thrombosis** **Dr. Zachary Liederman** – University Health Network
6:45 – 7:10	**TIPs for Harder-to-reach Specialty Consultations** **Hand Clinic –** Dr. Herb Von Schroeder **Ears, Nose & Throat –** Dr. Eric Monteiro
7:10 – 7:30	**Break-out Session** **Haley Gush** – University Health Network
7:30 – 7:50	**Outpatient Hip and Knee Replacement** **Dr. Michael Zywiel & Jesse Wolfstadt** – Women's College Hospital
7:50 – 8:00	**Closing Remarks** **Dr. Pauline Pariser** - Clinical Lead, Mid-West Sub-Region

Welcome

Dr. Pauline Pariser

Clinical Lead – Mid-West Sub-Region
SCOPE Physician Lead

Panel on Maximizing the Use of eConsult

eConsult in Toronto Central

Ian McMillan
econsult@wchospital.ca
416-323-6400 x4201

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What is eConsult?

- A secure web-based tool for primary care physicians and NPs to access **timely specialist advice** for all patients
- Frequently **eliminates the need** for a referral to an in-person visit
- Accessed through **OTNhub** (and select primary care EMRs)
- Specialists can provide eConsults **individually**, as **a team**, or as part of **province-wide groups**

eConsult BASE™
Ontario eConsult Centre of Excellence

Average response time is 2 days or less

Improved care coordination and collaboration

High patient and provider satisfaction

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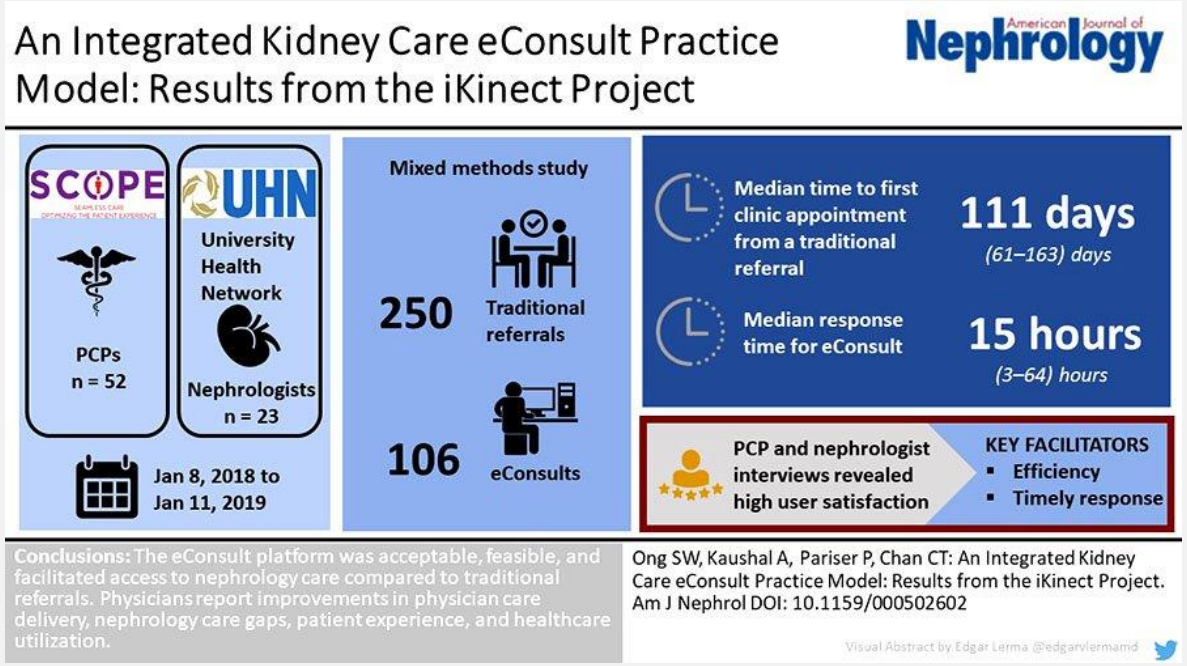
eConsult is already changing care in Toronto.

- A 2019 study by a team out of UHN with Dr. Chris Chan evaluated a central triage model for traditional referrals and eConsult to nephrology
- The 1-year pilot study looked at the various referral methods and their impact on access to care



- They found that the median response time for an eConsult was **15 hours** compared to **4 months** for a traditional referral
- Primary care physicians had **high satisfaction** due to the efficiency of eConsult and timely response
- Physicians reported improvements in **care delivery, care gaps, patient experience,** and **healthcare utilization**

Ong S, W, Kaushal A, Pariser P, Chan C, T: An Integrated Kidney Care eConsult Practice Model: Results from the iKinect Project. Am J Nephrol 2019;50:262-271. doi: 10.1159/000502602

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What is WCH's role?

- Women's College Hospital is the Toronto Central regional lead organization for eConsult

Outreach to primary care

Outreach & on-boarding for specialists

Awareness & on-the-ground support

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Specialty coverage in Toronto Central LHIN

Specialty	Cases sent from TC LHIN PCPs (last 12 months)	Specialists in TC LHIN	Provincial BASE™ Managed Specialty Group
Addiction Medicine	5	2	x
Anaesthesiology	9	6	x
Anesthesia - Pain Management		1	
Cardiac Surgery	3		x
Cardiology	185	8	x
Clinical Immunology and Allergy	33	1	x
Clinical Pharmacology	25	1	
Community Medicine		1	
Critical Care Medicine	12		
Dermatology	256	1	x
Diagnostic Radiology	33	2	
Emergency Medicine		1	
Endocrinology and Metabolism	263	6	x
Environmental Health	1	1	x
Gastroenterology	193	9	x
General Surgery	26	2	x
Geriatric Medicine	17	2	x
Gynecologic Oncology	28	4	x
Hematological Pathology		1	
Hematology	440	9	x
HIV	1	1	x
Infectious Diseases	222	5	x
Internal Medicine	129	20	x
Long-term Care		1	
Medical Genetics	23	3	x
Medical Oncology	15	2	x
Neonatal-Perinatal Medicine	4		x

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Nephrology	128	21	x
Neurology	167	3	x
Neurosurgery	25		x
Obstetrics and Gynecology	207	3	x
Ophthalmology	22		x
Orthopedic Surgery	85	2	x
Otolaryngology	73		x
Pain Medicine	5		x
Palliative Medicine	1	3	x
Pediatric Cardiology	9	1	x
Pediatric Endocrinology and Metabolism	1		x
Pediatric Gastro-Enterology	3		x
Pediatric General Surgery	2		
Pediatric Hematology	21		x
Pediatric Neurology	6		x
Pediatric Psychiatry	22	1	x
Pediatric Rheumatology	3		
Pediatric Urology	1		x
Pediatrics	108	7	x
Physical Medicine and Rehab	6	2	x
Plastic Surgery	14	1	x
Psychiatry	131	30	x
Radiation Oncology	2	1	x
Respirology	51	4	x
Rheumatology	48	2	x
Sports Medicine	1	1	
Thoracic Surgery	4	2	x
Transgender		1	x
Travel Medicine	1		
Urology	144	1	x
Vascular Surgery	24		x

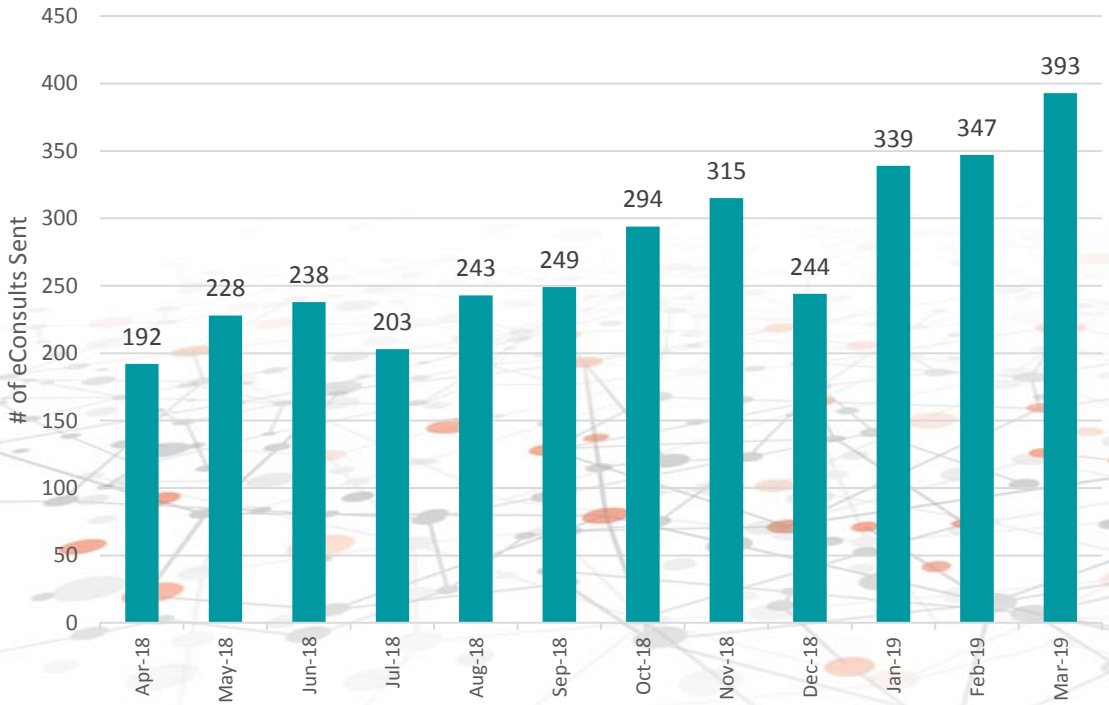
Self-managed specialty groups:

- Joint Department of Medical Imaging
- General Internal Medicine Consultants
- Dorothy Ley Hospice Community Physicians
- UHN General Nephrology
- UHN Transplant Nephrology

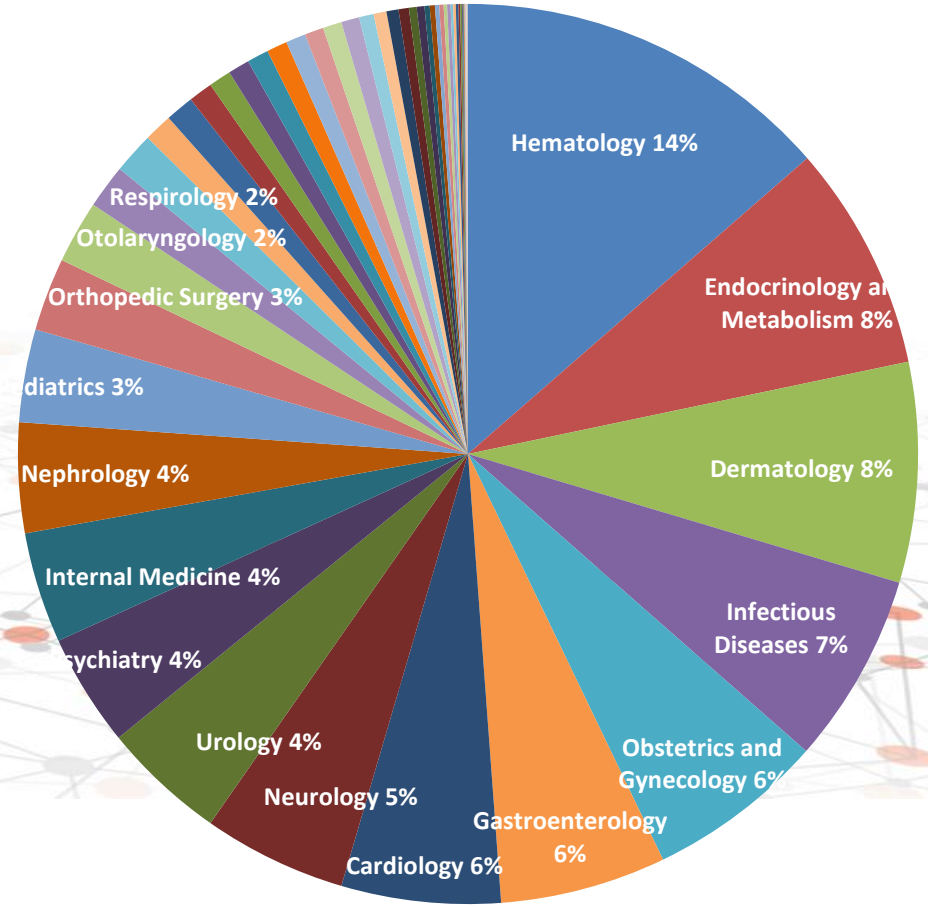
Snapshot – Toronto Central LHIN

Growth Over Time

eConsults per month



Specialties Submitted to by TC PCPs



1. Active means participated in 3 cases in the past 6 months

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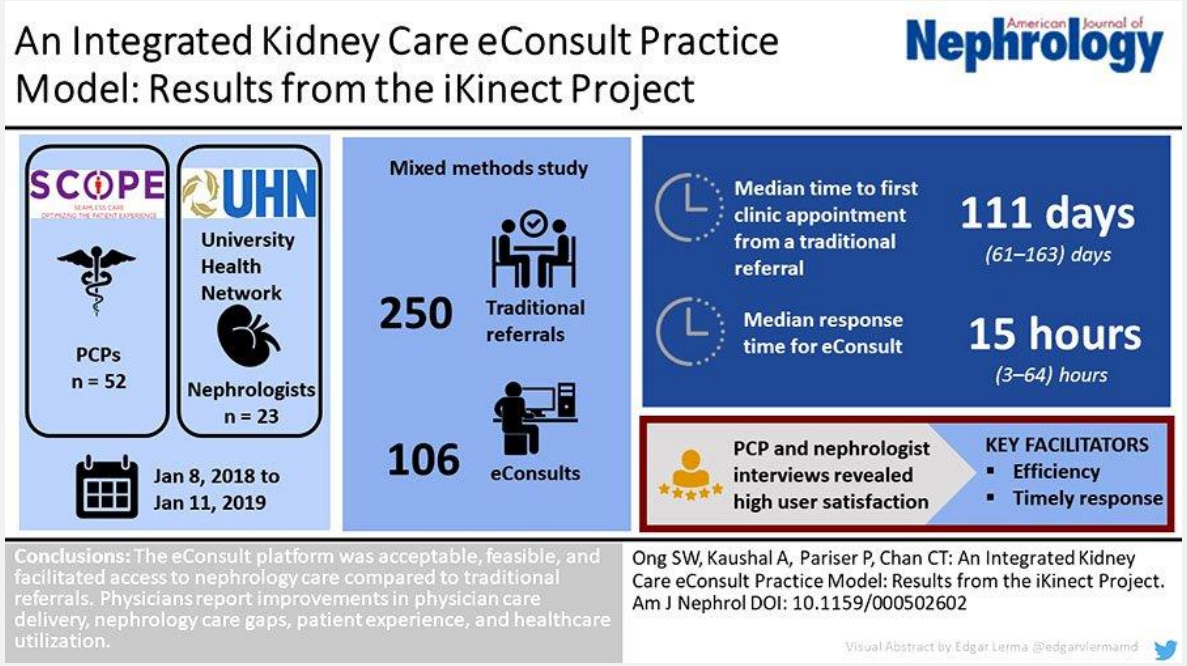

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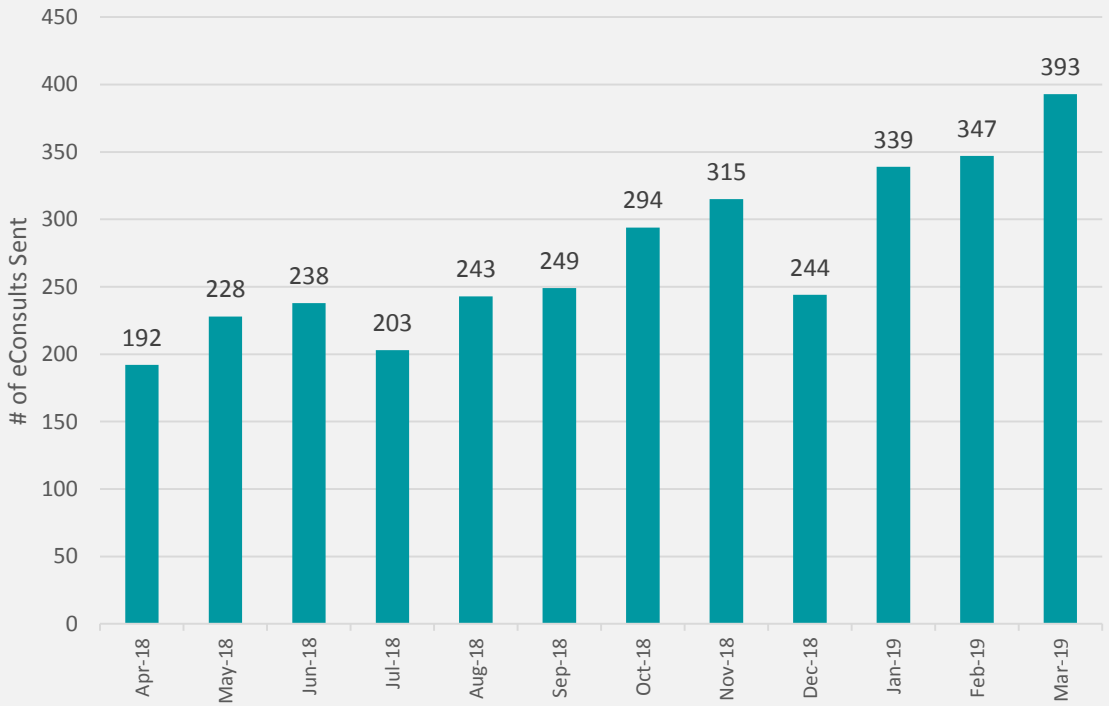

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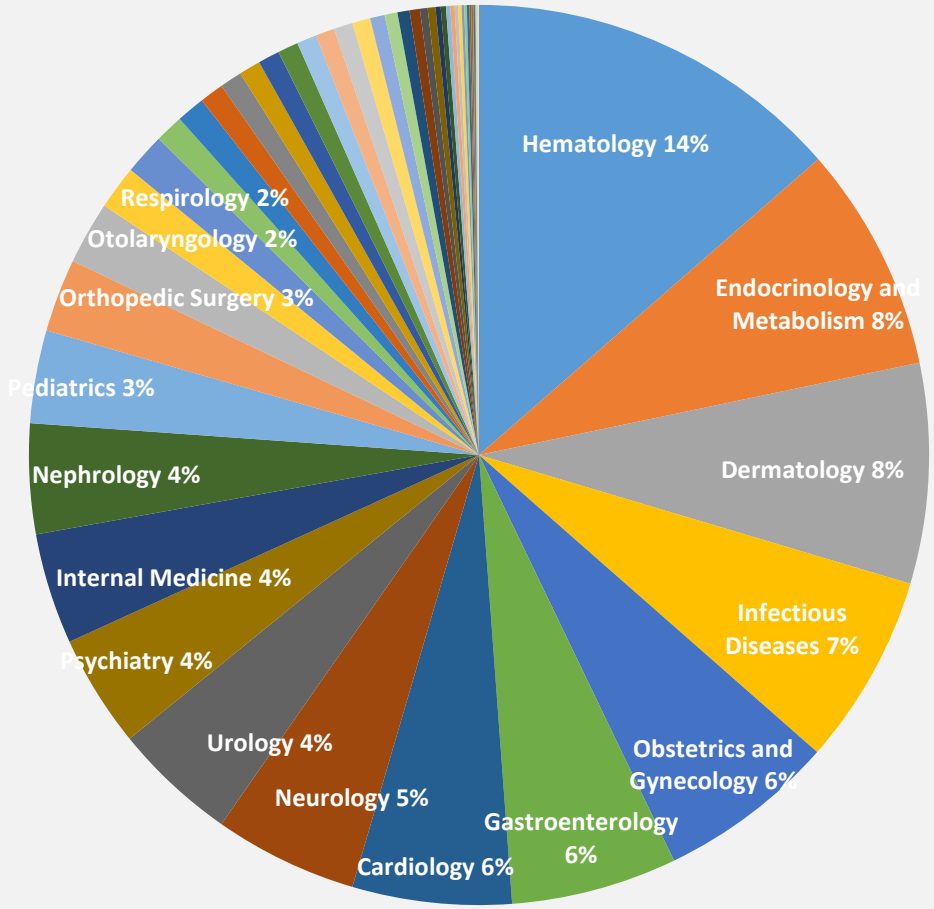

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Primary Care Engagement : SCOPE / Nephrology eConsult Collaborative Update

Dr. Christopher T Chan MD FRCPC
Director, Division of Nephrology - UHN
Professor of Medicine- University of Toronto
R Fraser Elliot Chair in Home Dialysis

Objectives

- Present 1 year Data
- Highlight ongoing strengths, challenges and opportunities
- Discuss future opportunities

Timeline

July 2017

Primary Care Physician Engagment Event

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OPTIMIZING THE PATIENT EXPERIENCE

August 2017

Primary Care and Nephrologists Onboard OTN eConsult.

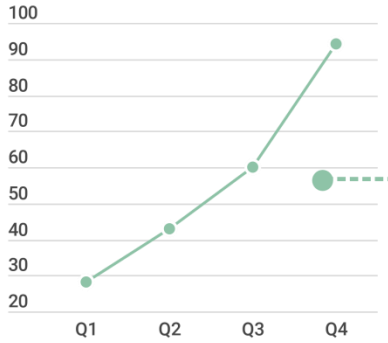
digitalUHN

otn Care. Connected.

OntarioMD Empowered Practices. Enhanced Care.

January 2018 Launch

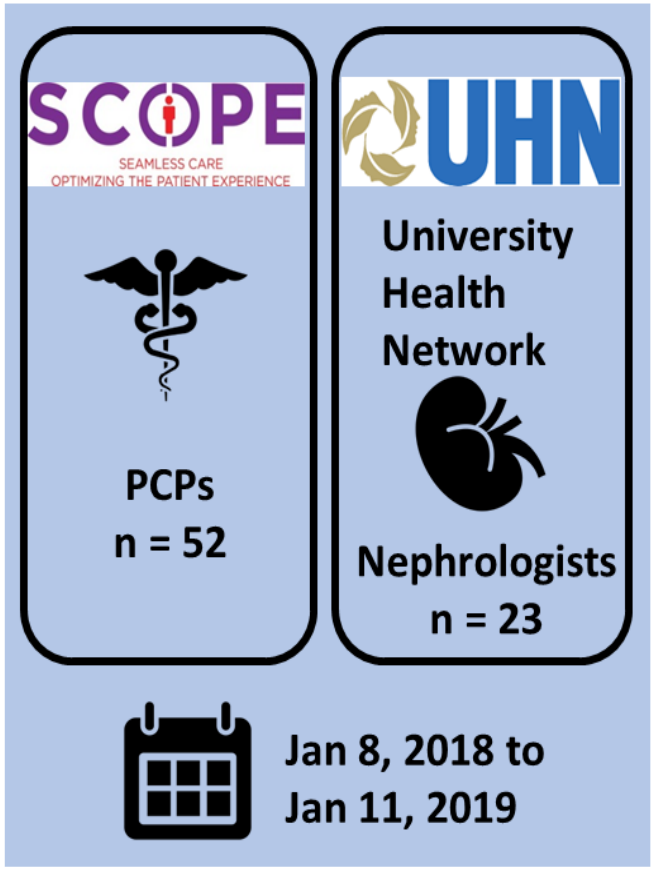
June 2018 – Phase 2 SCOPE Grp

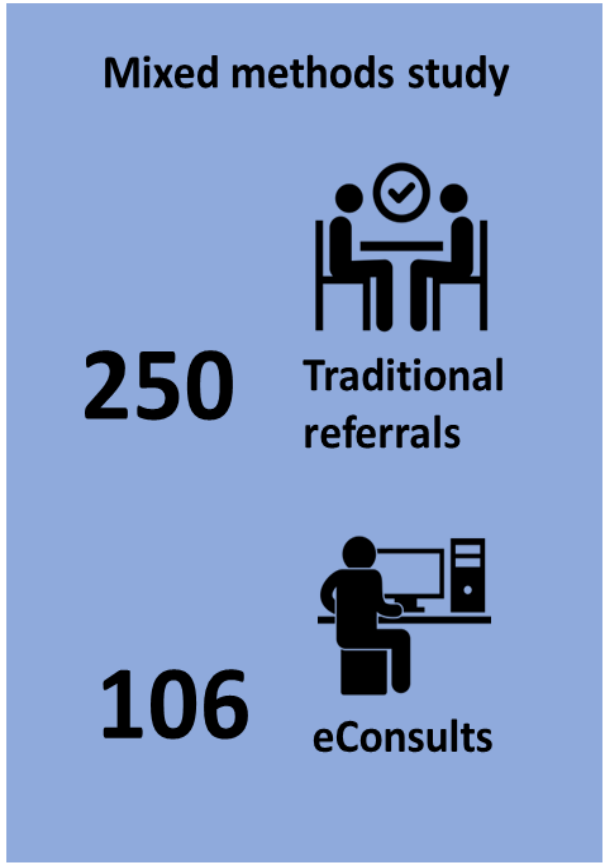


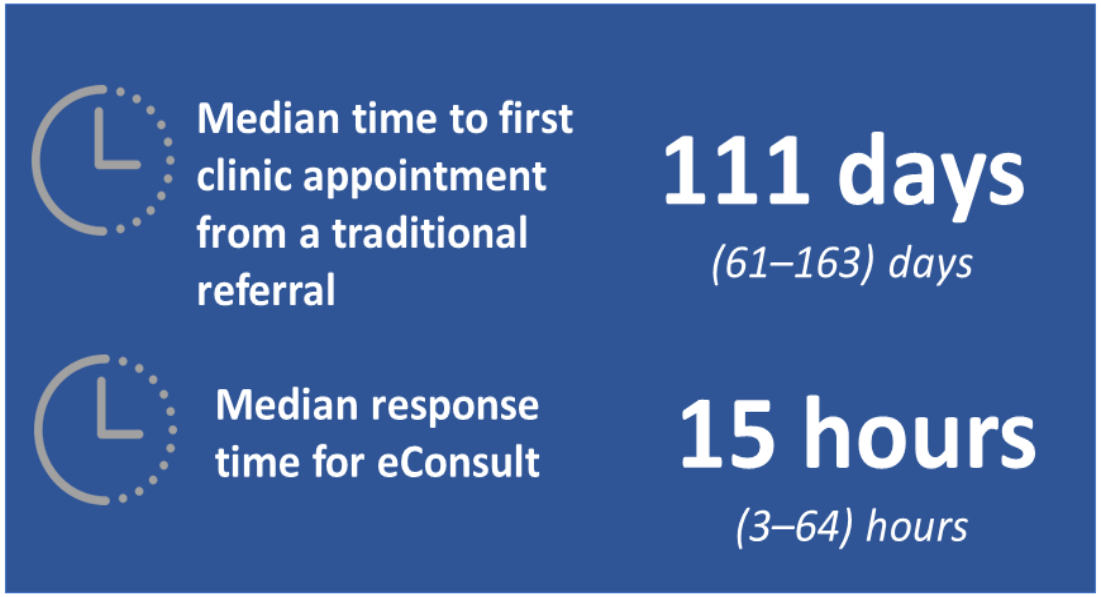
December 2018

An Integrated Kidney Care eConsult Practice Model: Results from the iKinect Project

American Journal of Nephrology





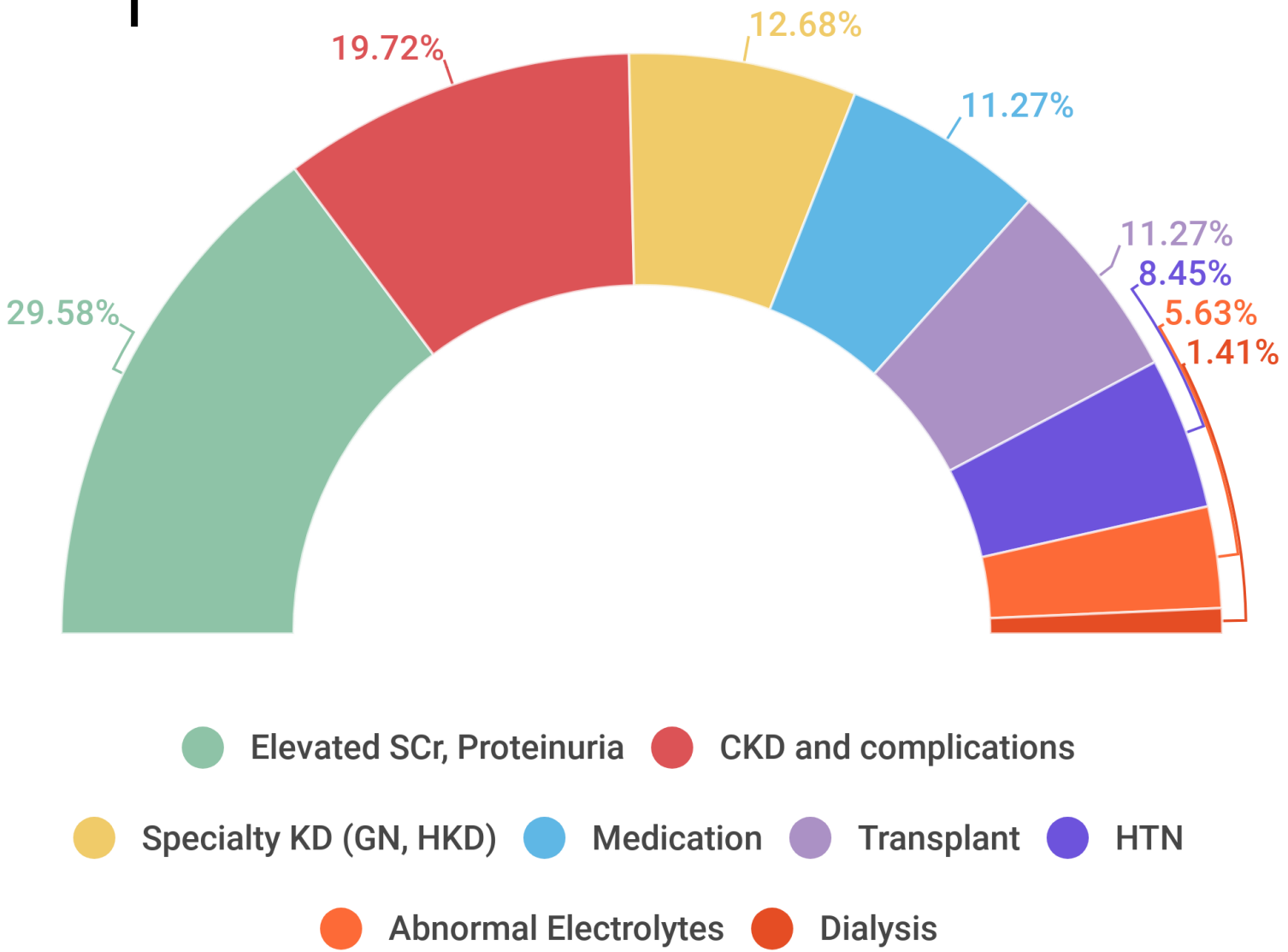


Conclusions: The eConsult platform was acceptable, feasible, and facilitated access to nephrology care compared to traditional referrals. Physicians report improvements in physician care delivery, nephrology care gaps, patient experience, and healthcare utilization.

Ong SW, Kaushal A, Pariser P, Chan CT: An Integrated Kidney Care eConsult Practice Model: Results from the iKinect Project. Am J Nephrol DOI: 10.1159/000502602

Visual Abstract by Edgar Lerma @edgarvlermamd

eConsult Cumulative Data



- Questions multi layered
  - Management (medication and additional monitoring, labs) ?
  - Interpretation of diagnostics ?
  - Need for referral ?

Need for Face to Face Visit?

Sample eConsults

No Referral Needed

- Febuxostat use in CKD
- Can we use a statin in CKD?
- What should I do with mild hyperkalemia in an outpatient setting?
- Elevated serum creatinine in the past year for 72 year old, should I refer?

Virtual Co-Management

- Complicated hypertension with multiple medications
- Diabetes Insipidus induced by Lithium
- Geriatric patient in nursing home for conservative management

Referral Suggested

- Complicated Hyponatremia
- Anemia related to CKD and when to start EPO
- Complicated HTN with multiple medications and need to medication enhancement
- Increased serum creatinine in elderly and may require discussion on conservative care

Referral Needed/ Face to Face Visit Needed

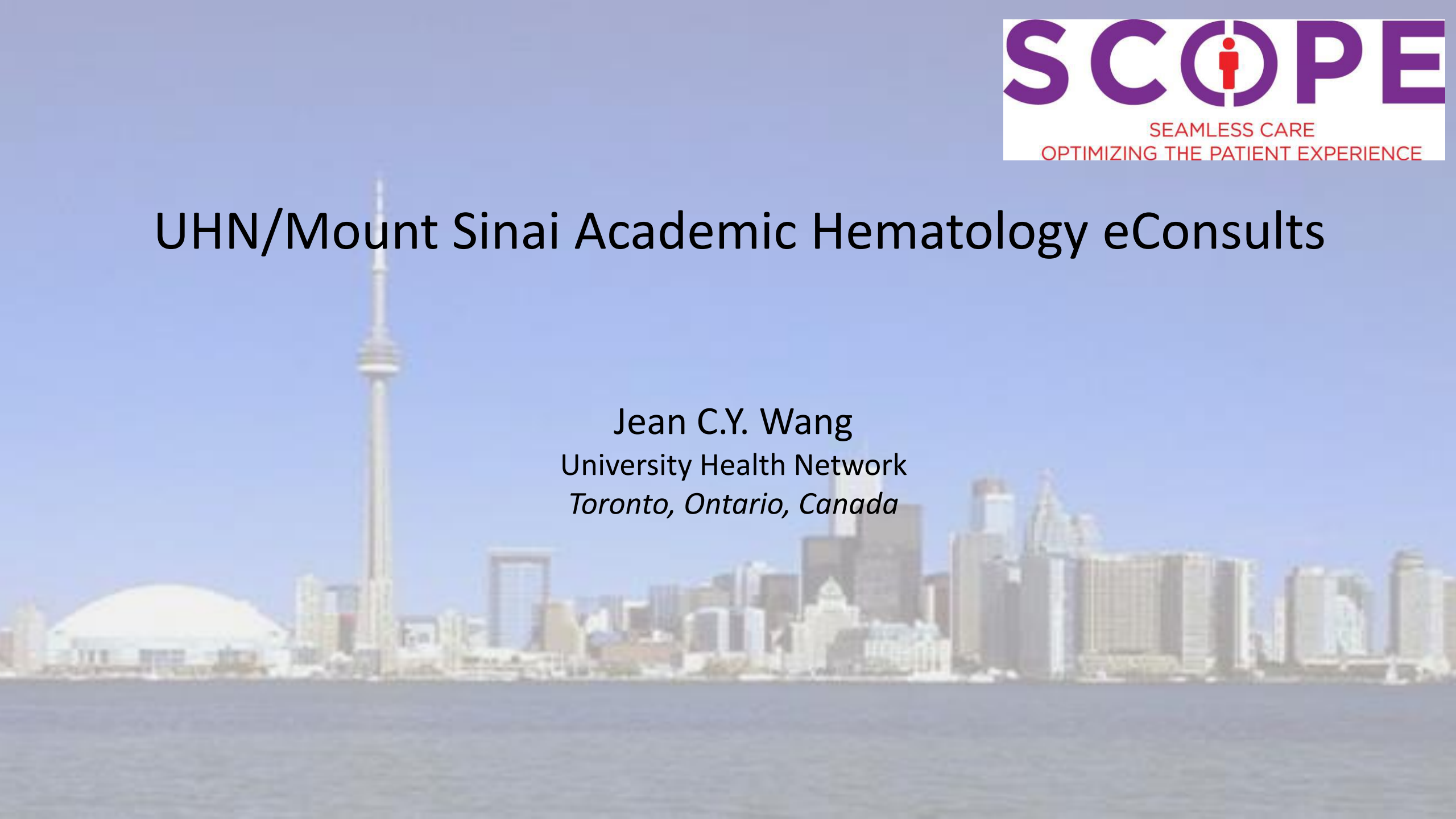
- Kidney biopsy required potential glomerulonephritis
- Growing kidney cysts requiring genetic testing
- Patient on DOAC and experiencing a bleed need ER referral

Next Steps: Virtual Corridor

Advanced Diabetes Management (SGLT2 Care Pathway)

CKD Complication (Electrolyte – hyperkalemia care)

Virtual Hypertension Clinic

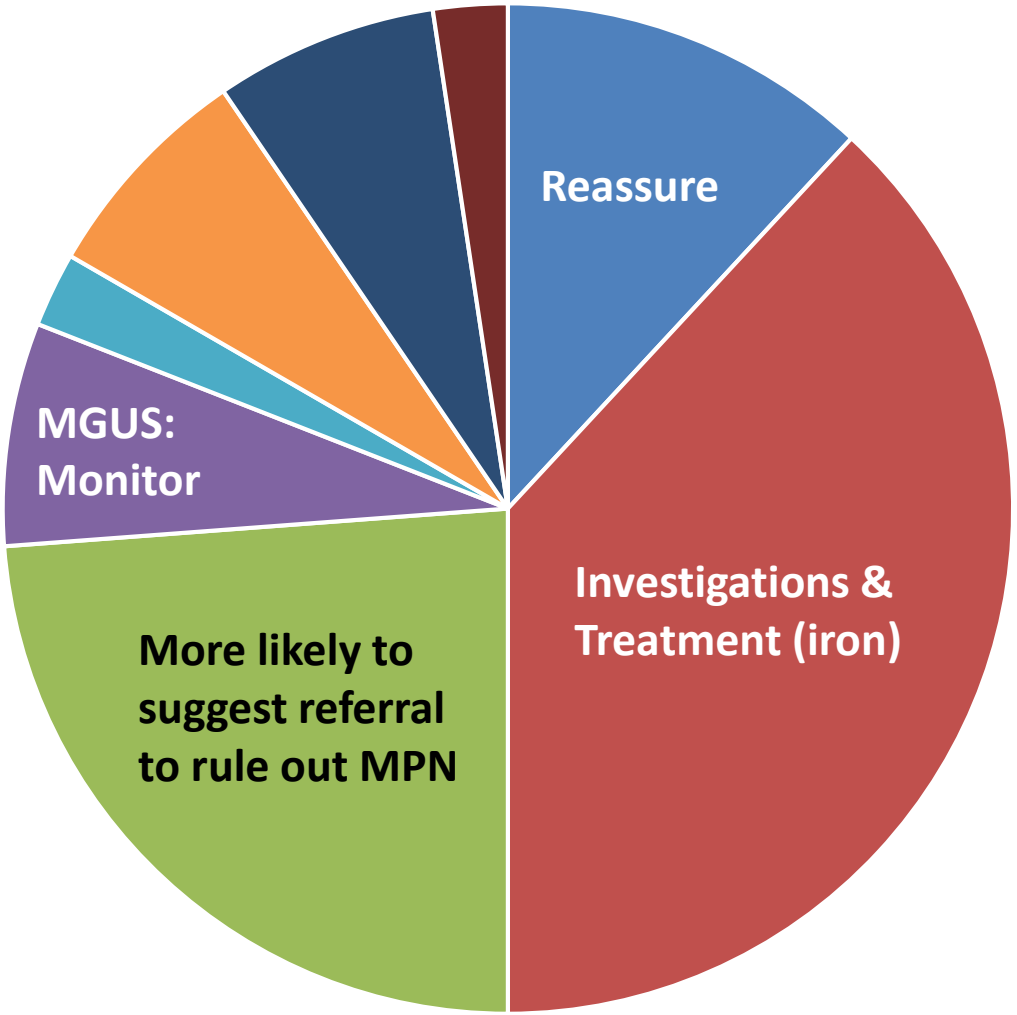


UHN/Mount Sinai Academic Hematology eConsults

Jean C.Y. Wang
University Health Network
Toronto, Ontario, Canada

eConsults Overview – types of questions

n = 42



- Incidental findings
  - micro/macrocytosis, giant Plts, high B12
- Low blood counts
  - anemia, thrombocytopenia, neutropenia, iron deficiency
- High blood counts
  - Hb, Neutrophils, Plts, Lymphocytes
- M protein
  - incidental: osteoporosis, neuropathy
- Genetic hemochromatosis
- Thrombosis
- Management/referral Q
- Miscellaneous

eConsults Overview

- eConsults provides resolution for cases with single uncomplicated issue:
  - Mild isolated abnormal hematologic parameter with otherwise normal CBC
  - Cytopenias or elevated cell counts
  - Incidental finding of low level monoclonal protein
- Advice re initial investigations - follow up with eConsult or referral if abnormal
- Advice re management e.g. iron supplementation
- Advice for monitoring and when to refer
- Complex cases better suited for direct referral
- If referral is needed, eConsults can help to expedite investigations and triage process

eConsults – in-person assessment required for complexity

Case submitted April 27, 2019

83M recurrent refractory ITP

March 14: platelets 7, admitted to hospital for IVIG, prednisone
April 10: returned to hospital, platelets 12, IVIG, prednisone
April 27: sent to ER for platelets 5, still on high-dose prednisone
Has appt with hematology in 10 days

Q: Continue with steroids? Add TPO or Ritux? Wait for hematology?

- Too much acuity and complexity
- Requires in person assessment

(Case was cancelled so outcome not known)

eConsults – expedited investigations and referral

Case submitted February 12, 2019

78M UHN lung transplant patient

Returned from trip to South America with bloody diarrhoea and worsening anemia
Sent to TGH ER but no transfusion or IV iron, sent for assessment by gastroenterologist,
who suggested hematology referral

Q: Possible to see soon at Hematology clinic at TGH?
Any investigations in the meantime?

- Bloodwork ordered at UHN lab
- Appointment in UHN hematology clinic March 4

eConsults – advice and deferred referral

Case submitted March 27, 2019

34F pregnant (19/40) with elevated ferritin (400s) and homozygous C282Y mutation in HFE gene

Planning to refer for genetic counselling at MSH

Q: Additional investigations?
Referral to hematologist needed?

- Advice re investigation and management (could be deferred until post-partum)
- Advice re genetic counselling of family members (referral to MSH genetics not needed)
- Referral to hematology post-partum for counselling and management advice (seen Oct 2019)

Primary Care Perspective

Dr. Rui Martins

Questions

Scope – Thrombosis Update

Zachary Liederman
Zachary.liederman@uhn.ca

Content

1) Thrombophilia testing in high risk patients

2) Which long term warfarin patients can switch to a DOAC

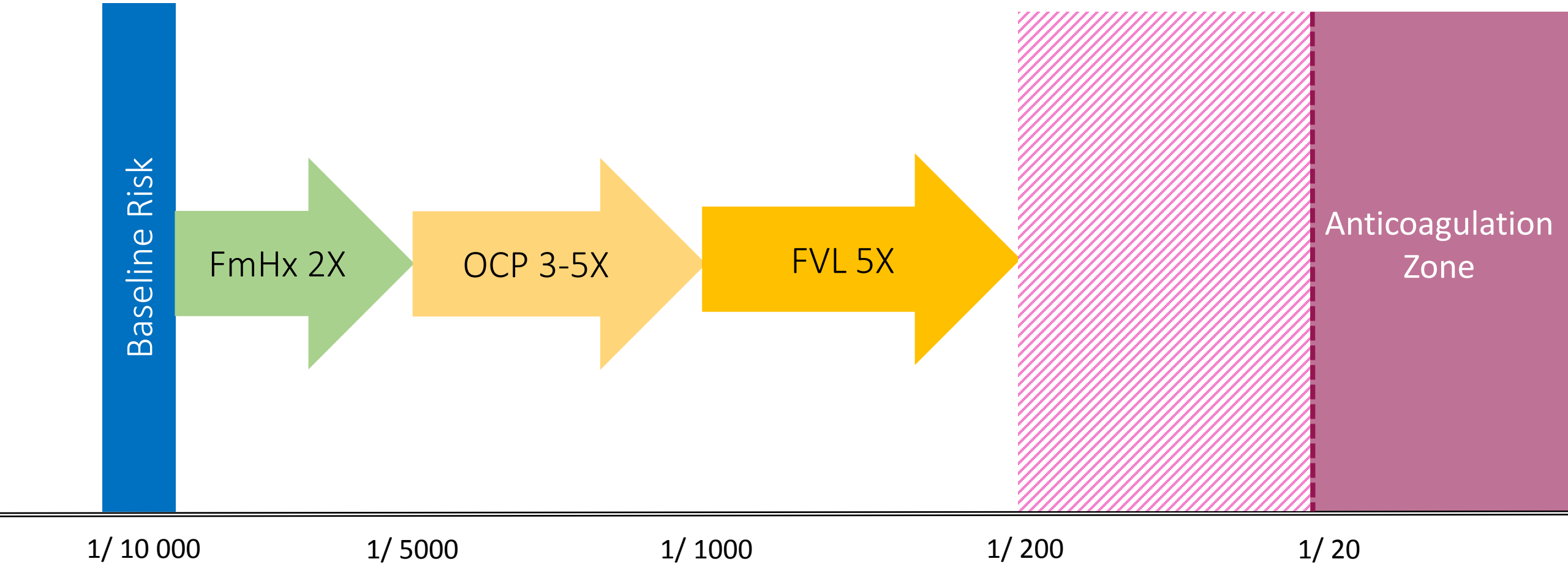
3) Perioperative anticoagulation

Case 1

23 year old previously well female

- Mother diagnosed with unprovoked PE (FVL)
- Considering hormonal birth control options
- ? thrombophilia testing

Risk of 1st VTE with thrombophilia



Key points

No role for thrombophilia testing without family hx

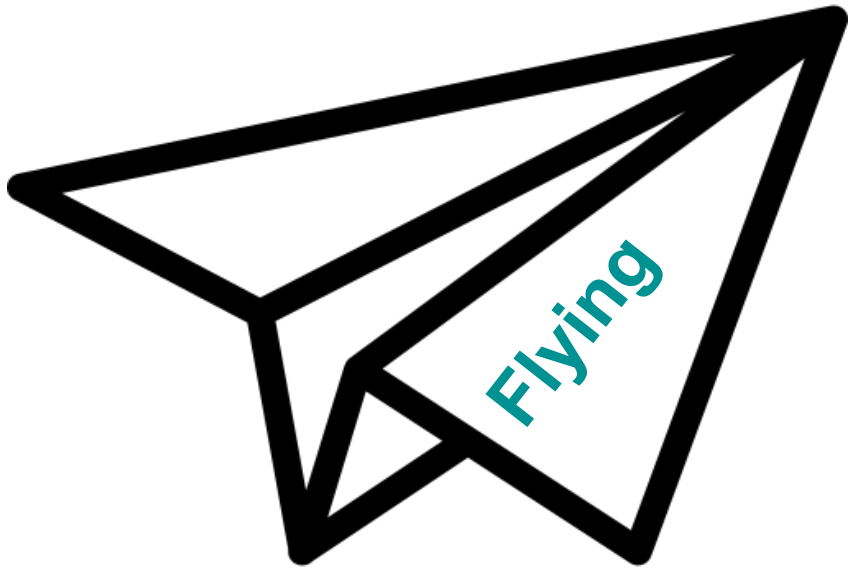
With (+) family hx

- Increased risk regardless of thrombophilia testing
- Preference for lower risk contraception
  - IUD, Progestin only pill

- (+) Thrombophilia testing → increased relative risk but low absolute risk … unlikely to change management for most patients

Lightning Round - other thrombotic challenges

? 2X Risk
(50 year old male on Testosterone:
~ 1/ 500 → 1/200 if + FVL)



3X Risk (< 1/5000 flights*)

Aisle seat, hydration, ambulation
High Risk: GCS, *proph AC

Walker RF, et al. *JAMA Intern Med*. 2019.

Case 2

65 year old male

- Unprovoked PE 20 years ago
- Long term Warfarin use
- Comorbidities: DM2, HTN

-? switch to DOAC

Warfarin is still preferred for…

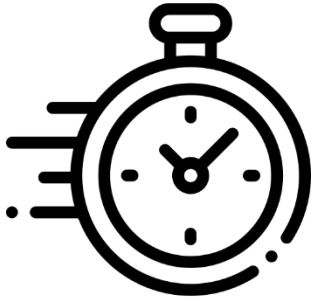
- Mechanical valves
- VTE and Renal failure (CrCl < 15 or imminent risk)
- Drug Interactions (check Thrombosis Canada Resource)
  - Amiodarone, Dilantin, Carbamazapine
- Financial constraints (DOAC ~ $100/ month)
- Extremes of weight (<50 kg or > 140 kg)

**Potential pregnancy (with switch to LMWH)

Otherwise consider referral for DOAC

Less blood work

Decreased ICH



Shorter half life

Option for dose reduction

Perioperative use of DOAC's – Post Pause Trial

DOAC	Surgical Procedure-Associated Bleeding Risk	Preoperative DOAC Interruption Schedule						Postoperative DOAC Resumption Schedule			
		Day -5	Day -4	Day -3	Day -2	Day -1		Day +1	Day +2	Day +3	Day +4

Stable uncomplicated patient:

- **Low risk procedure (cataracts, dental, scopes) → last dose day -2**
- **High risk procedure → last dose day -3**

Renal impairment, high thrombotic risk (Stroke/VTE < 3 months, mech valve, CHADS2 = 5 or 6) → refer (econsult)

Douketis JD, et al. *JAMA Intern Med*. 2019.

Take home points

- Limited role for thrombophilia testing to determine use of hormone treatment
- Most patients would benefit from a switch to a DOAC
- Perioperative DOAC: hold for 1 vs. 2 days

Bleeding on DOACs

	Dabigatran	Rivaroxaban	Apixaban	Edoxaban
Major Bleeding AFIB	No difference	No difference	REDUCED	REDUCED
Major Bleeding VTE	No difference	No difference	REDUCED	No difference
Major Bleeding VTE Extend	No difference	No difference	No difference	-
ICH AFIB	Trend ↓	Trend ↓	REDUCED	REDUCED
ICH VTE	Trend ↓	Not Reported	Trend ↓	REDUCED
ICH VTE Extend	Trend ↓	No difference	No difference	-
GI Bleeding AFIB	Trend ↑	Trend ↑	Trend ↓	**INCREASED**
GI Bleeding VTE	Trend ↑	Not Reported	REDUCED	No difference
GI Bleeding VTE Extend	Trend ↓	No difference	No difference	-
CRNMB AFIB	Trend ↓	No difference	REDUCED	REDUCED
CRNMB VTE	Trend ↓	No difference	REDUCED	REDUCED
CRNMB VTE Extend	Trend ↓	No difference	No difference	-
Studies	RE-LY RE-COVER RE-SONATE	ROCKET AF EINSTEIN EINSTEIN CHOICE	ARISTOTLE AMPLIFY AMPLIFY EXT	ENGAGE TIMI AF HOKUSIA VTE

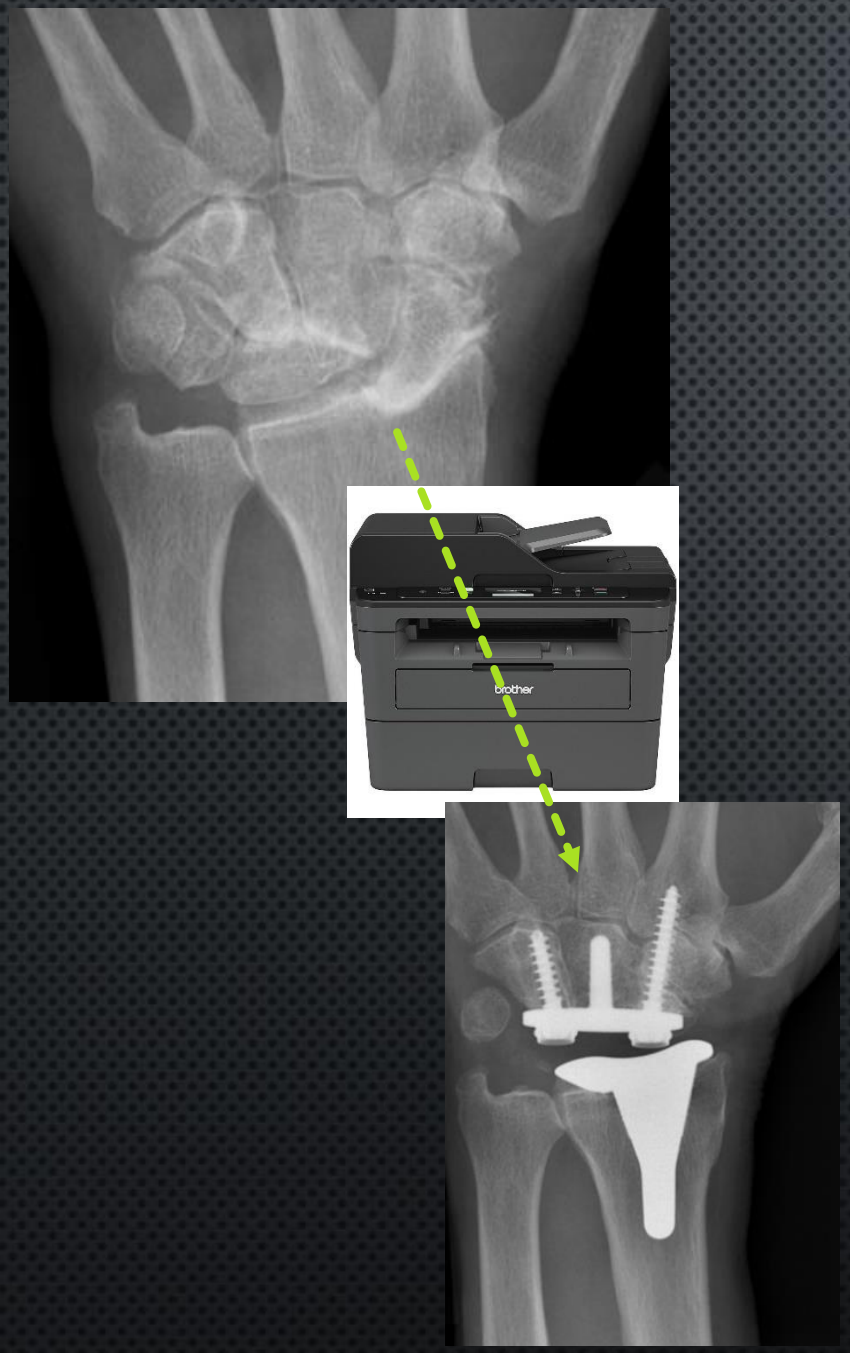
Renal Function and DOACs

DOAC	Renally Clearance	Dosing
Dabigatran	80 % (50-60% removed by dialysis)	• **CrCl < 30 mL/min = contraindicated**
Rivaroxaban	36 %	• **CrCl < 15 mL/min = not recommended** • CrCl 15-50 mL/min = 15 mg daily for AFIB

Apixaban	27 %	• **CrCl < 15 mL/min = not recommended**
		CrCl 15 – 30 mL/min = caution with AFib
		• 2.5 mg po bid if two of the following in AFib:
		  • Creatinine > 133 mcmol/L
		  • Age > 80
		  • Weight < 60 kg

Edoxaban	50 %	• **CrCl < 30 mL/min = not recommended** • CrCl 30-50 mL/min = 30 mg daily (or weight < 60 kg or P-gp inhibitor)

Tips for Harder-to-reach Specialty Consultations



ACCESS

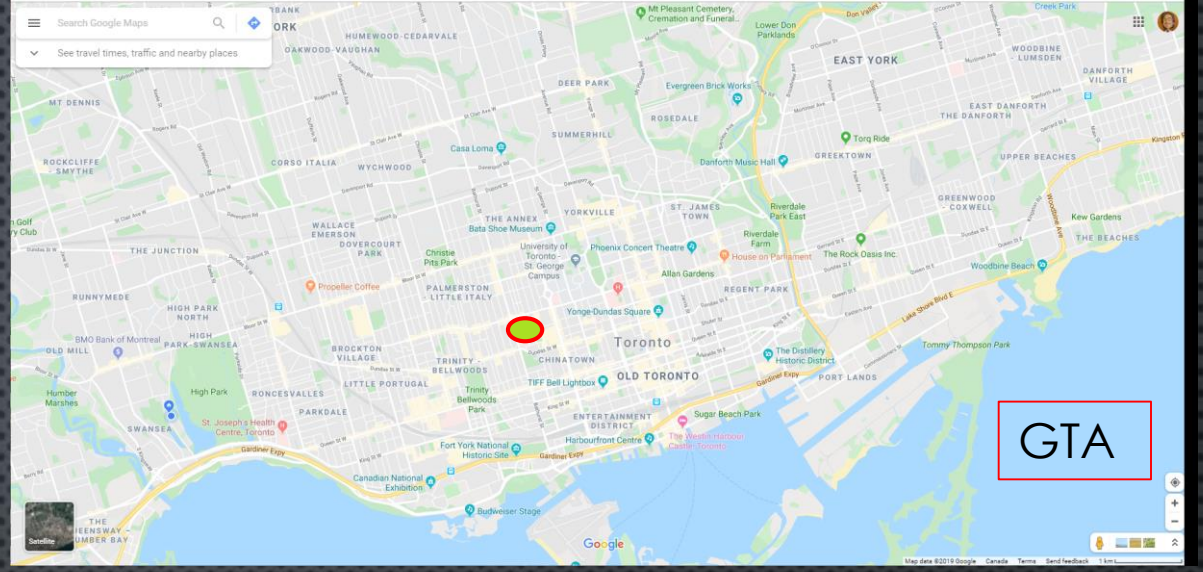
HERB VON SCHROEDER, MD

HAND AND WRIST SURGEON, UNIVERSITY HAND PROGRAM, TWH

MEDICAL DIRECTOR, HAND AND UE, ALTUM HEALTH

ASSOCIATE PROFESSOR, UNIVERSITY OF TORONTO

WHO WE ARE

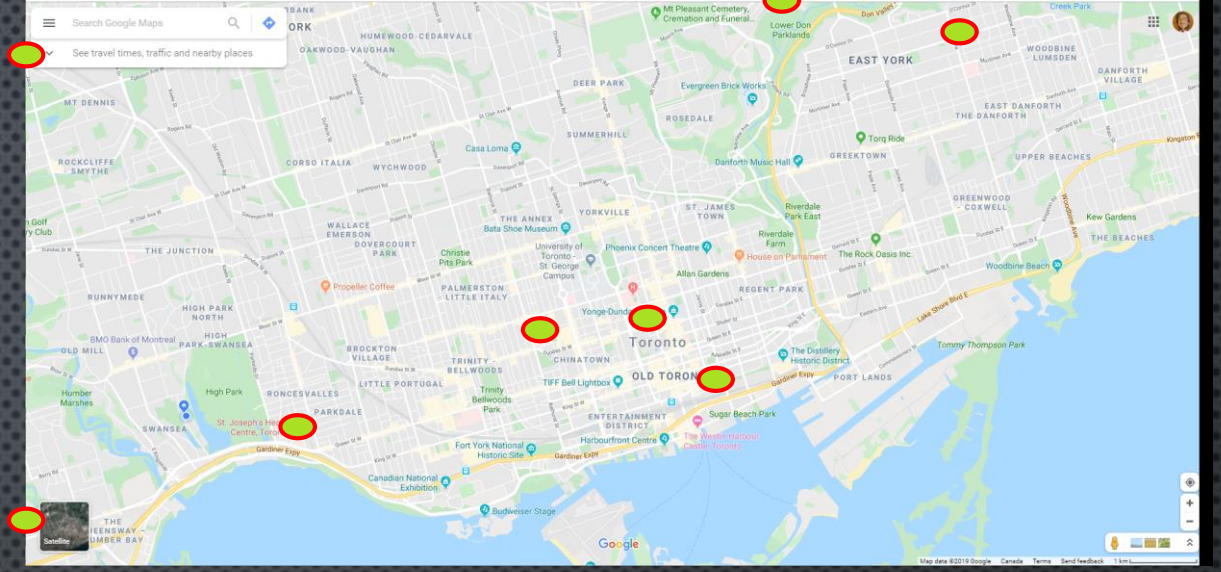


HAND PROGRAM – TWH – UHN

- 5 + 2 HAND SURGEONS (ORTHO/PLASTICS)
- 8 HAND THERAPISTS

- FAX 416-603-5392

HAND SURGEONS

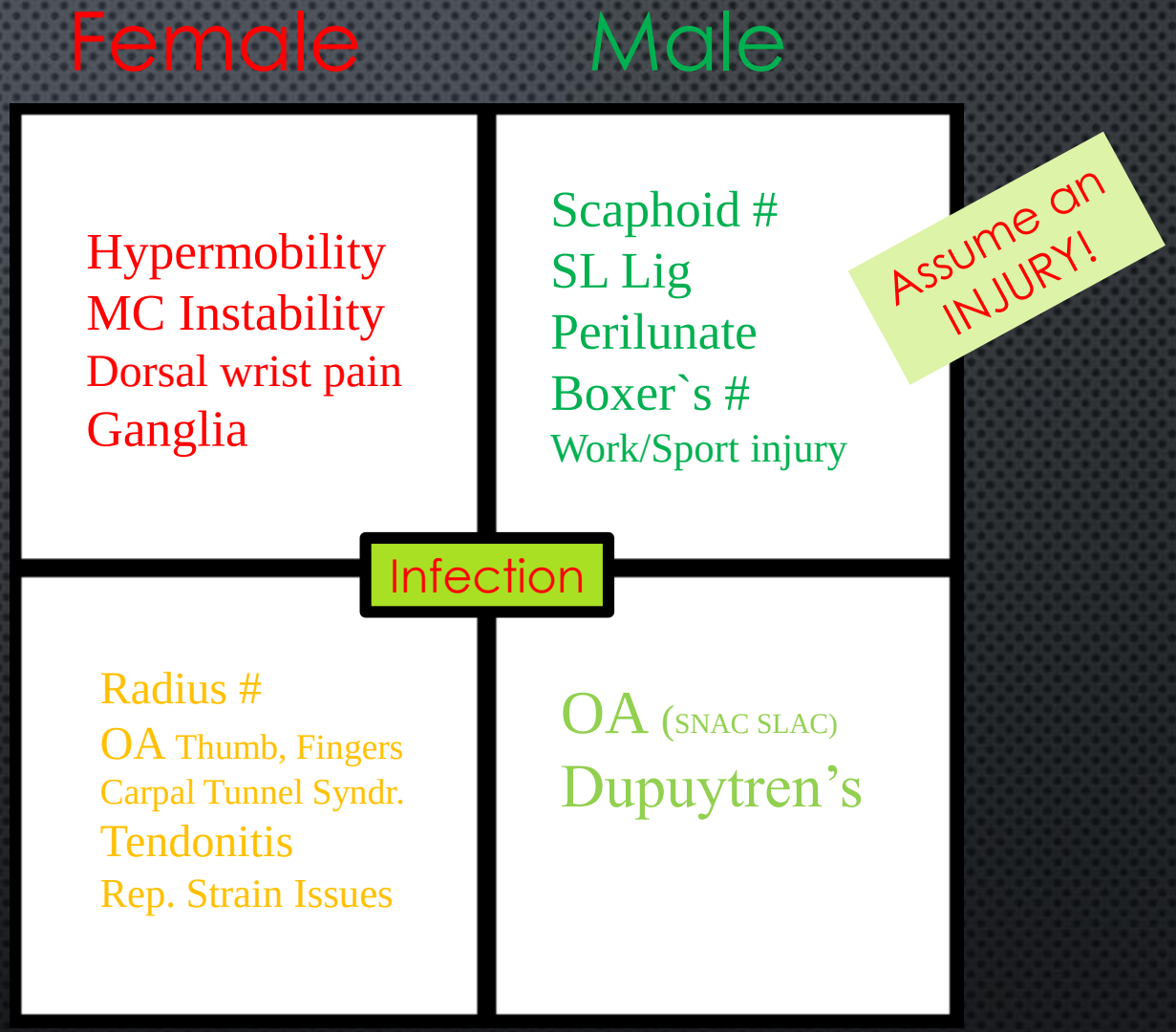


- AT MOST HOSPITALS
- DIRECTORY
  - UPDATED
  - ACCESSIBLE
  - ACCURATE INFO
  - LINKED TO EMR

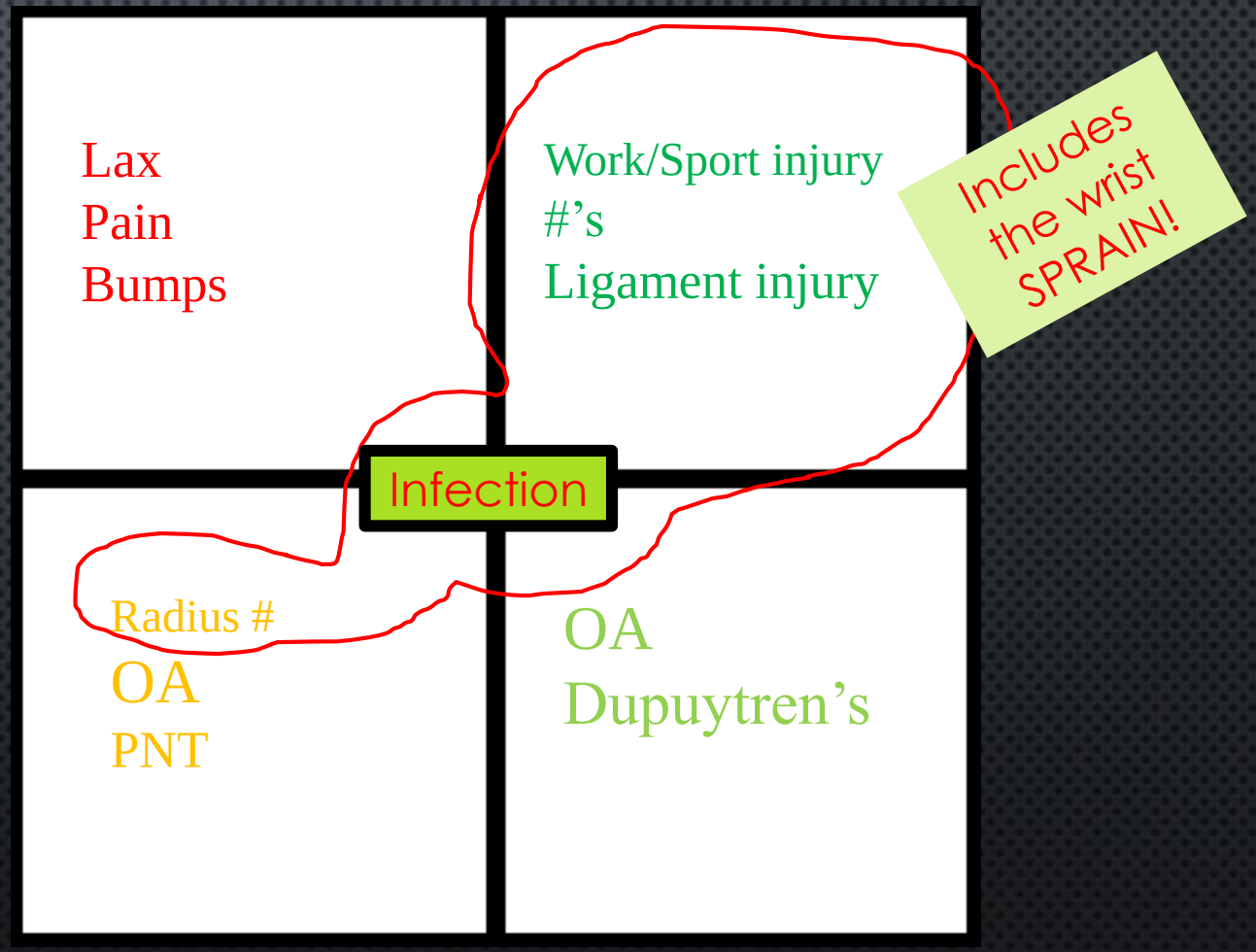
WHAT WE SEE & DO

- NO: DERM
- TRAUMA, ARTHRITIS, LUMPS & BUMPS, NEUROPATHIES, TENDONITIS…..
- 20% SURGICAL

INJURIES AND ISSUES



TRAUMA AND TEARY



EMERGENCIES: TO THE **ER**

THE TEARY

- NSAIDS
- SPLINT
- CORTISONE INJ.
- TIME

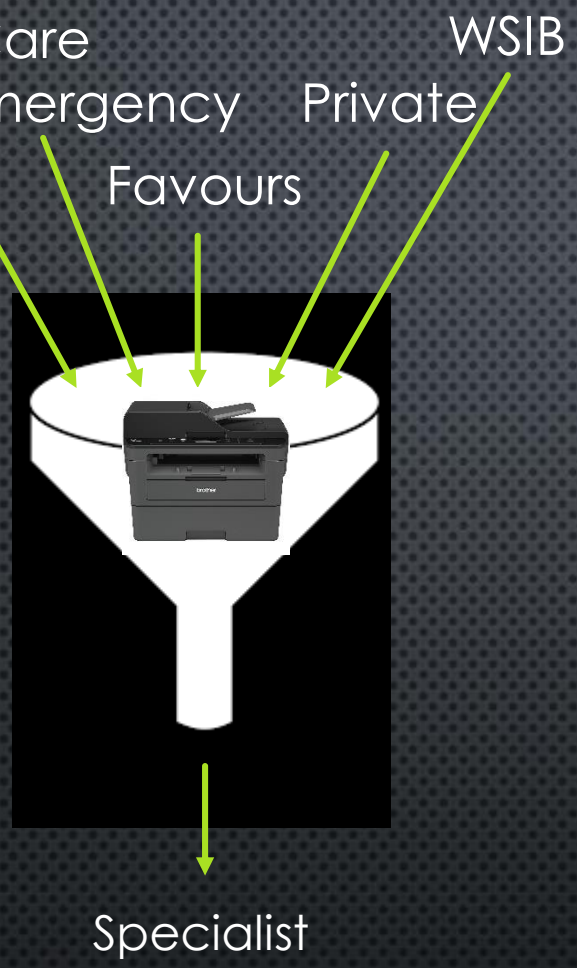
Lax Pain Bumps	
OA PNT RSI	OA Dupuytren's

ACCESS

Primary Care

Specialist

ACCESS



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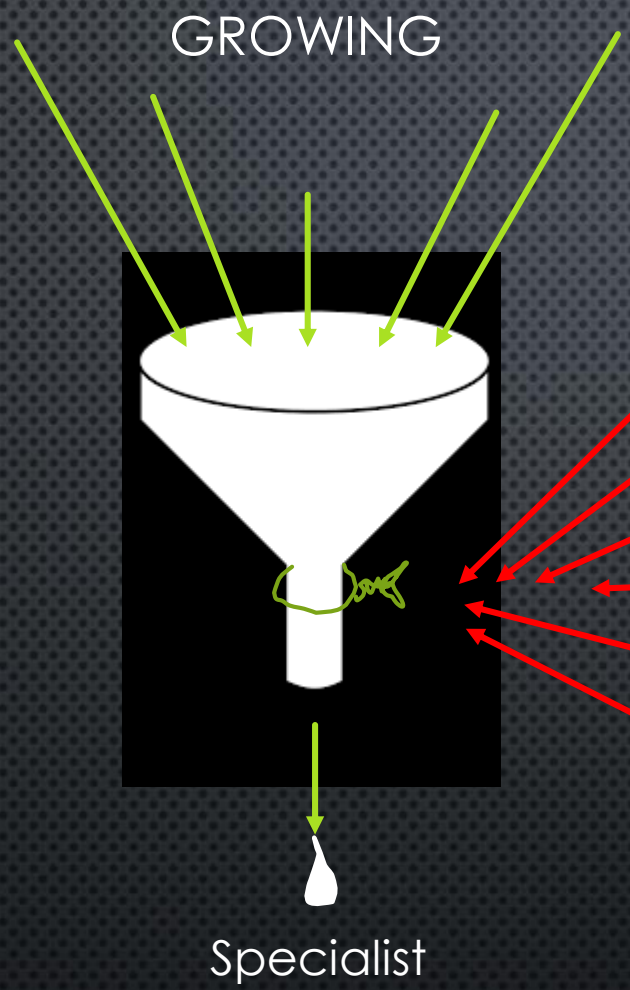


RESOURCES

AVAILABILITY

ON LEAVE

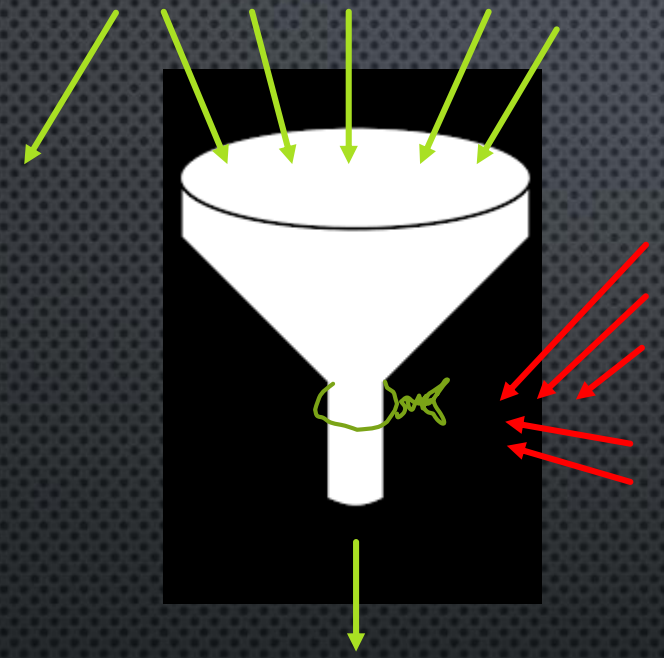
ADMIN, TEACH, RESEARCH

SNOWFLAKE

SUBSPECIALTY

BYPASS?

Primary Care



Specialist

PHONE?

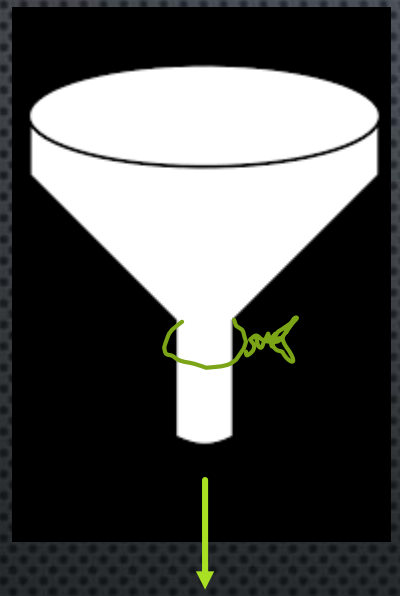
EMAIL?

SWITCHBOARD?

What can we do to improve the referral process?

REJECTION

Primary Care



Specialist

NO

THE FIX: PRIMARY CARE

- TREAT: NSAIDS, CORTISONE, SPLINT
  - CME
- STOP THE TESTS: EMG, MRI, (X-RAYS YES)
- STOP THE THERAPY
- ROUTINE POST-OP CARE
- ADVOCATE HEALTH CARE REFORM

Building Capacity, Reducing Referrals, Saving Time & Money

THE FIX: SPECIALTY CARE

- TRAIN AND RETAIN $
- JOBS JOBS JOBS
- RESOURCES…. $

THE FIX: SPECIALTY CARE

- TRAIN AND RETAIN $
- JOBS JOBS JOBS
- RESOURCES…. $

- PA'S
- BUNDLED CARE
- RAPID ACCESS CLINICS

Building Capacity, Accepting Referrals, Spending Time & Money

END

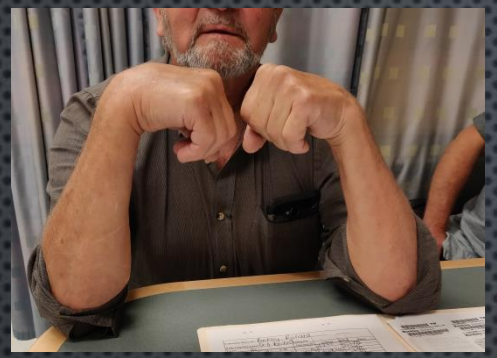
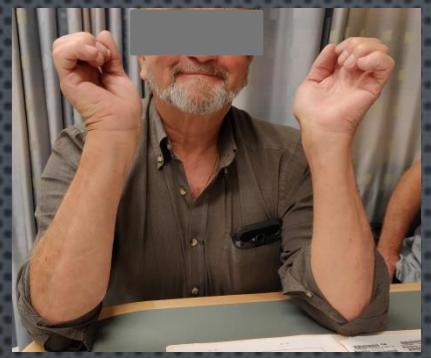
- Treat More
  - Educate
- Order Less
- Refer: Trauma and Infections

END

Efficiencies

- Treat More
  - Educate
- Order Less
- Refer: Trauma and Infections

- Our System …

Thank-You

Herb.vonSchroeder@outlook.com

Otolaryngology Referrals:

Some Practical Tips

ERIC MONTEIRO

MD, MSC, FRCSC

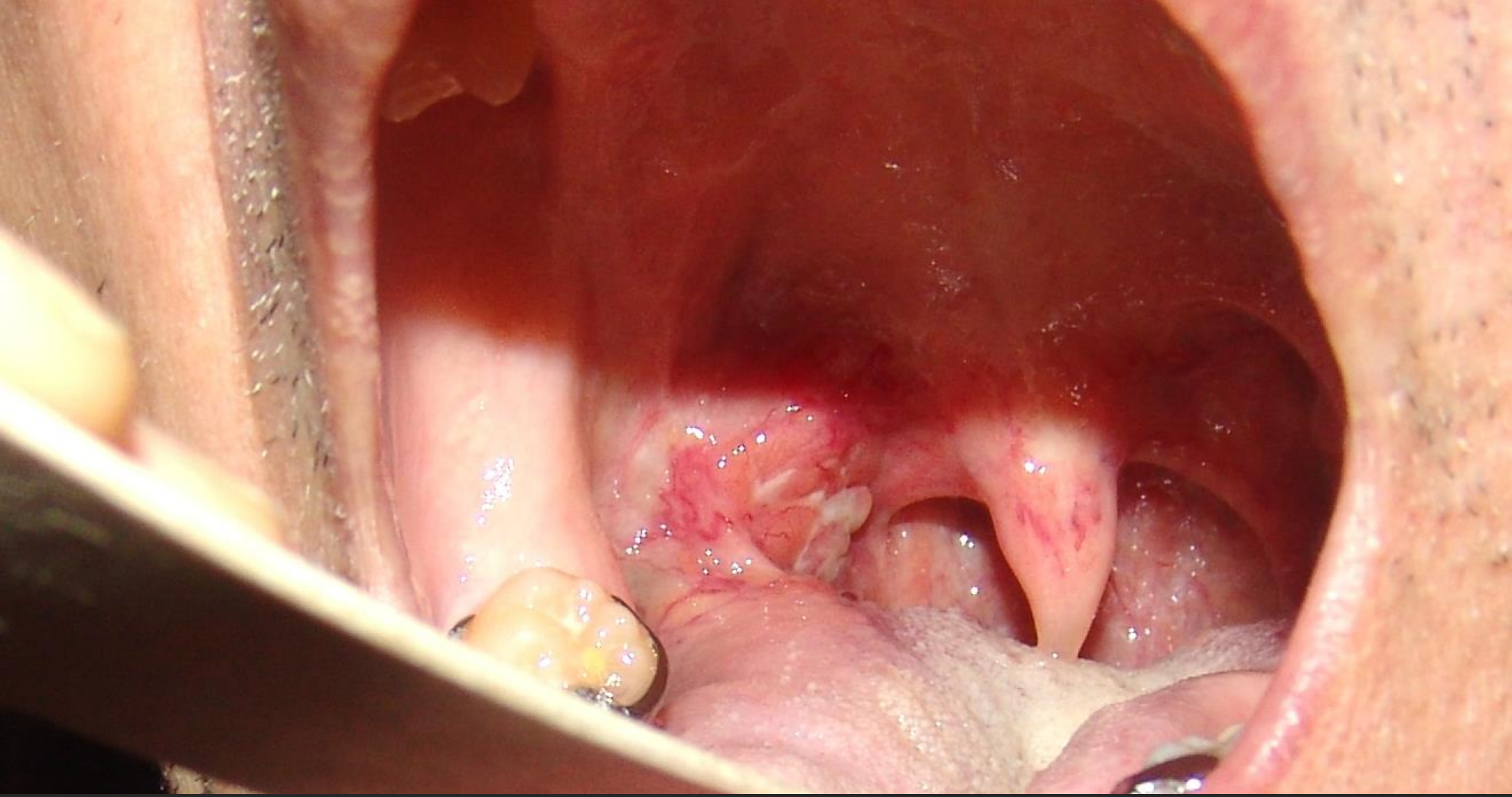
ASSISTANT PROFESSOR

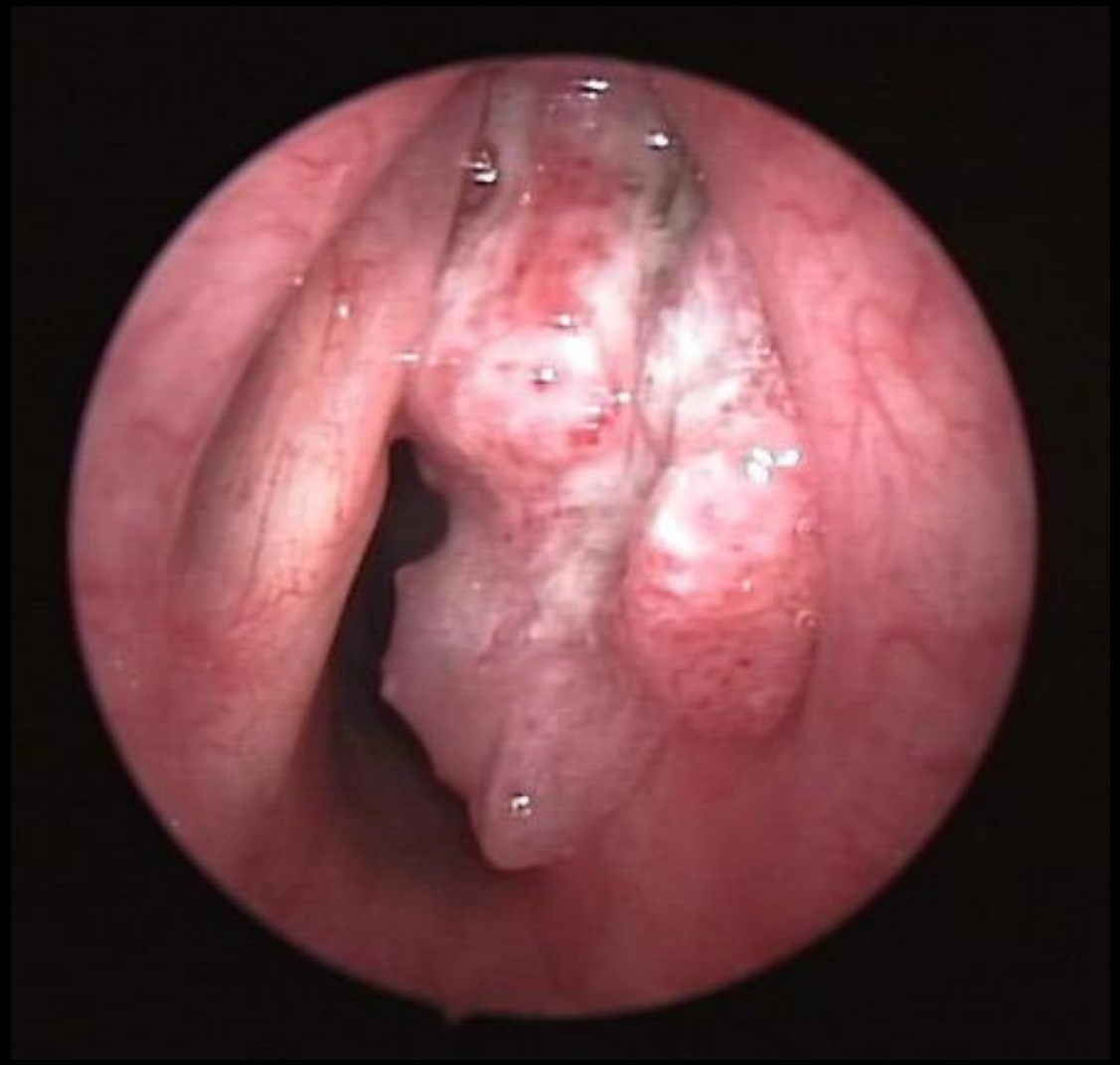
UNIVERSITY OF TORONTO

SINAI HEALTH SYSTEM

- Sudden vs Gradual?
- Pain?
- Appearance of TM and EAC?

- Timing?
- Associated otologic symptoms – hearing loss
- Examination findings?
- Neurologic Symptoms





Sorry

Questions

Break-Out Session

Outpatient Hip and Knee Replacement

SCOPE Physician Engagement

Drs. Michael Zywiel and Jesse Wolfstadt

Tuesday November 26th, 2019

WCHH
WOMEN'S COLLEGE HOSPITAL
Health care for women | REVOLUTIONIZED

Acknowledgements

Dr. David Urbach
Victoria Noguera
Thanh Vu
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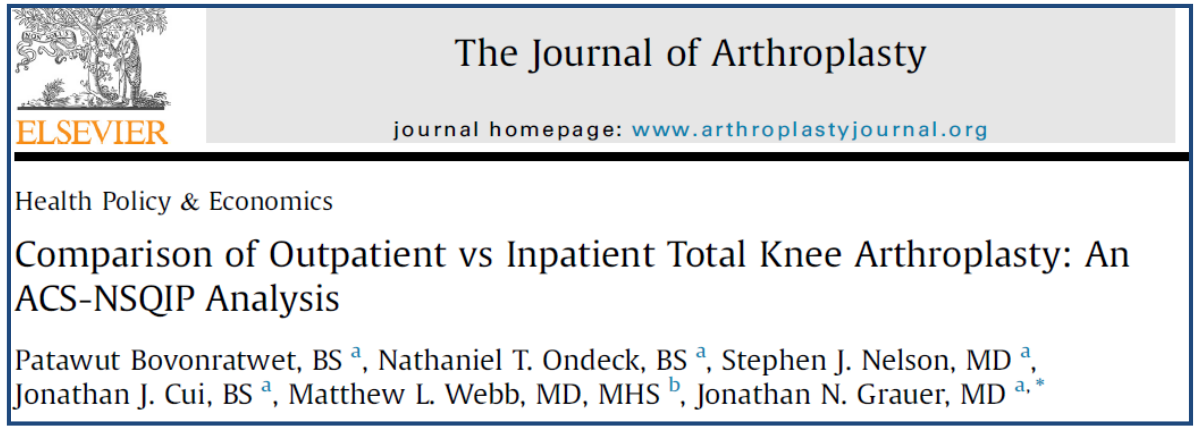
Gillian Grant
Dr. David Backstein
Dr. Ricky Brull
Dr. Daniel Cornejo Palma
Ashley Graham

Overview

1. Why
2. Who
3. How

Why?



The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

Health Policy & Economics

Comparison of Outpatient vs Inpatient Total Knee Arthroplasty: An ACS-NSQIP Analysis

Patawut Bovonratwet, BS [a], Nathaniel T. Ondeck, BS [a], Stephen J. Nelson, MD [a], Jonathan J. Cui, BS [a], Matthew L. Webb, MD, MHS [b], Jonathan N. Grauer, MD [a,*]

The Journal of Arthroplasty xxx (2017) 1–10

Contents lists available at ScienceDirect

The Journal of Arthroplasty

journal homepage: www.arthroplastyjournal.org

Review Article

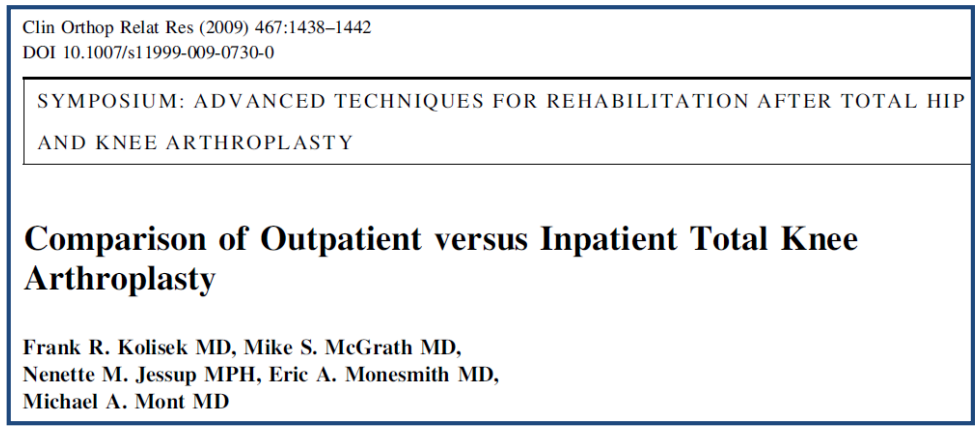
The Shift to Same-Day Outpatient Joint Arthroplasty: A Systematic Review

Jeffrey D. Hoffmann, MD [a], Nicholas A. Kusnezov, MD [a], John C. Dunn, MD [a], Nicholas J. Zarkadis, DO [a,*], Gens P. Goodman, DO [a], Richard A. Berger, MD [b]

The Journal of Arthroplasty Vol. 20 No. 7 Suppl. 3 2005

Outpatient Total Knee Arthroplasty With a Minimally Invasive Technique

Richard A. Berger, MD, Sheila Sanders, RN, Tad Gerlinger, MD, Craig Della Valle, MD, Joshua J. Jacobs, MD, and Aaron G. Rosenberg, MD



Clin Orthop Relat Res (2009) 467:1438–1442
DOI 10.1007/s11999-009-0730-0

SYMPOSIUM: ADVANCED TECHNIQUES FOR REHABILITATION AFTER TOTAL HIP AND KNEE ARTHROPLASTY

Comparison of Outpatient versus Inpatient Total Knee Arthroplasty

Frank R. Kolisek MD, Mike S. McGrath MD, Nenette M. Jessup MPH, Eric A. Monesmith MD, Michael A. Mont MD

Experience of Care

⇩ Pain

⇩ Nausea

⇧ Satisfaction

THE STAR

News • GTA

He got his knee replaced at a Toronto hospital. A few hours later he was climbing stairs

By **Theresa Boyle** Health Reporter
Wed., April 11, 2018

It's been less than four hours since Greg Nemez underwent knee-replacement surgery and the 56-year-old Mississauga man is already on his way home from hospital.

This past Monday, he became the fifth patient at Toronto's Women's College Hospital to undergo the outpatient procedure, which normally requires a hospital stay of two or three days.

General principles

Get back to normal life as quickly and safely as possible

There's no place like home

Discharge other than home associated with

- Slower recovery
- Higher rate of readmission with adverse events

Safe discharge

When is it safe to go home?

- Medically stable
- Pain controlled
- Mobilizing safely for home environment

Who is appropriate for outpatient TJA?

- Potentially up to 55% of TKA/THA patients

Who is appropriate?

At WCH → no strict criteria

- Willing patient with adequate supports at home
- No BMI cutoff
- No age cutoff (although caution with 75+)
- Well-controlled comorbidities (HTN, T2DM, etc.)

Who is not appropriate?

ABSOLUTE

Untreated bleeding disorder

Substance abuse

Active therapy with disease-modifying drugs (DMARDs) that cannot be timed appropriately with surgery

Marked organ dysfunction

RELATIVE

No one at home night of surgery

History of severe PONV

Chronic pain

Poorly controlled OSA

Anticoagulant therapy

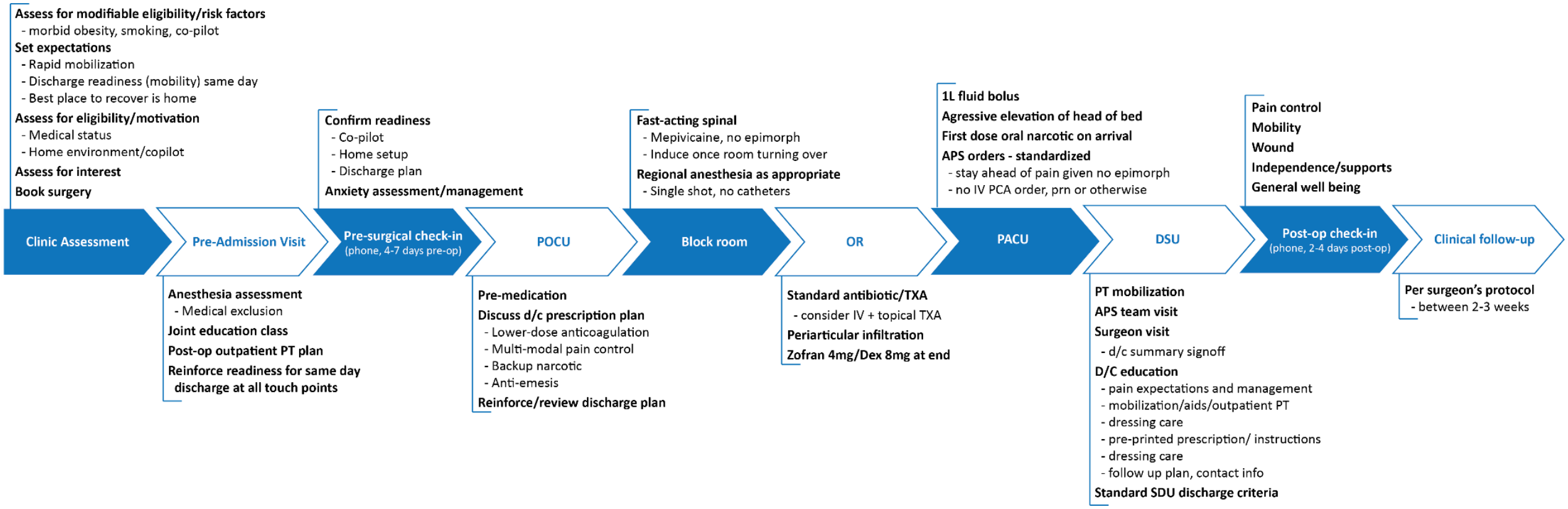
Then and Now

WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

How?

WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

Shared decision making → plan entire patient journey together



How?

Pre-emptively address potential barriers BEFORE they arise

- Patient anxiety
- Blood loss
- Nausea/vomiting
- Urinary retention
- Pain (in hospital and post-discharge)
- Pain medication side effects
- Inadequate home environment
- Post-discharge patient concerns

Pre-Admission

Identify co-pilot

Post-discharge rehab plan

Prepare self and home environment

Pre-admission visit

Pre-surgery check-in call

Consistent messaging from team is critical

How?

Education	Set expectations, manage anxieties, prepare patient, be aspirational!
Pain	Pre-medication Opioid sparing muli-modal oral analgesia Spinal anaesthetic, nerve blocks, local infiltration by surgeon
Nausea	Pre-medication Intraoperative Dexamethasone and Ondansetron Opioid sparing oral analgesia; aggressive post-operative hydration
Mobilization	No foley, no PCA; head of bed elevated Short-acting spinal, motor-sparing nerve blocks Early mobilization, no restrictions/precautions
Support	Pre and post-discharge support

Pre-operative diagnostic tests

WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED

KNEE

Standing AP, lateral, and skyline knee x-rays

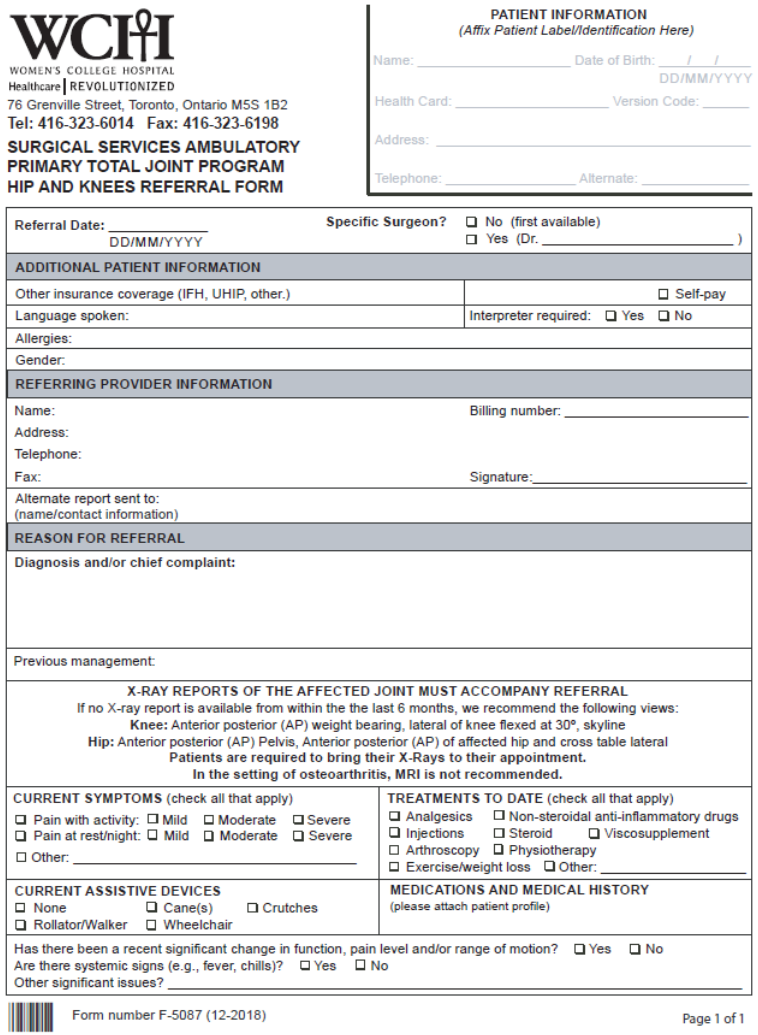
HIP

Standing AP pelvis, AP and lateral hip x-rays

* In general, patients should have an XR before additional imaging is ordered
* MRI not indicated in patients >65 years of age

Referrals

https://www.womenscollegehospital.ca/programs-and-services/Total-Joint-Replacement-Program



WCH
WOMEN'S COLLEGE HOSPITAL
Healthcare | REVOLUTIONIZED
76 Grenville Street, Toronto, Ontario M5S 1B2
Tel: 416-323-6014 Fax: 416-323-6198

SURGICAL SERVICES AMBULATORY
PRIMARY TOTAL JOINT PROGRAM
HIP AND KNEES REFERRAL FORM

PATIENT INFORMATION
(Affix Patient Label/Identification Here)

Name: _____ Date of Birth: ___/___/____ DD/MM/YYYY
Health Card: _____ Version Code: _____
Address: _____
Telephone: _____ Alternate: _____

Referral Date: _____ DD/MM/YYYY
Specific Surgeon? ❑ No (first available) ❑ Yes (Dr. _____)

ADDITIONAL PATIENT INFORMATION

Other insurance coverage (IFH, UHIP, other.)	❑ Self-pay
Language spoken:	Interpreter required: ❑ Yes ❑ No
Allergies:	
Gender:	

REFERRING PROVIDER INFORMATION

Name: Billing number: _____
Address:
Telephone:
Fax: Signature: _____
Alternate report sent to:
(name/contact information)

REASON FOR REFERRAL

Diagnosis and/or chief complaint:

Previous management:

X-RAY REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL
If no X-ray report is available from within the the last 6 months, we recommend the following views:
Knee: Anterior posterior (AP) weight bearing, lateral of knee flexed at 30°, skyline
Hip: Anterior posterior (AP) Pelvis, Anterior posterior (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 AND MEDICAL HISTORY
(please attach patient profile)

Has there been a recent significant change in function, pain level and/or range of motion? ❑ Yes ❑ No
Are there systemic signs (e.g., fever, chills)? ❑ Yes ❑ No
Other significant issues? _____

Form number F-5087 (12-2018)
Page 1 of 1

How to address patient concerns/fears

Email us!

jesse.wolfstadt@sinaihealthsystem.ca

michael.zywiel@uhn.ca

THANK YOU

Questions

Thank You!