



REQUEST FOR ORTHOPAEDIC CONSULTATION

Referral Date:	YYYY	MM	DD
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CONSULTATION REQUESTED FROM: (select one)

Note: if no selection is made, referral will be processed as "next available".

Next available appointment within any Toronto Region Hospital — FAX to (416) 599-4577
Toll Free: 1-877-411-4577

Hospital (select hospital and fax to identified number):

- | | |
|---|---|
| <input type="checkbox"/> Holland Orthopaedic & Arthritic Centre (Fax: 416-599-4577) | <input type="checkbox"/> Michael Garron Hospital (Fax: 416-469-6145) |
| <input type="checkbox"/> Mount Sinai Hospital (Fax: 416-586-3213) | <input type="checkbox"/> St. Joseph's Health Centre (Fax: 416-530-6691) |
| <input type="checkbox"/> St. Michael's Hospital (Fax: 416-864-5817) | <input type="checkbox"/> Toronto Western Hospital (Fax: 416-603-5765) |

Dr. _____ (identify orthopaedic surgeon and fax to hospital using fax numbers above)

Physician Information	Referring Physician Information	Patient Information	
	Name: _____		Name: _____
	Specialty: _____		Address: _____
	Address: _____		Date of Birth: _____
	Phone: _____		Health Card #: _____ VC: _____
	Fax: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Email: _____		Language if unable to speak English: _____
	Billing #: _____		Phone (Home): _____
	Signature: _____		Phone (Work): _____
	Family Physician Information (if different)		Phone (Cell): _____
Name: _____	Email: _____		
Phone: _____	WSIB #: _____		

Clinical Information	DIAGNOSIS: <input type="checkbox"/> Hip Right / Left <input type="checkbox"/> Knee Right / Left <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Inflammatory arthritis <input type="checkbox"/> Fracture <input type="checkbox"/> Post-traumatic arthritis <input type="checkbox"/> Failed hip or knee replacement <input type="checkbox"/> Joint derangement not yet diagnosed <input type="checkbox"/> Other: _____	CONSIDERATION FOR: <input type="checkbox"/> Primary Replacement: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Opinion on <u>prior</u> replacement: <input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Opinion Requested: <input type="checkbox"/> Hip <input type="checkbox"/> Knee URGENCY: <input type="checkbox"/> Routine <input type="checkbox"/> Urgent
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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

Clinical Information	CURRENT SYMPTOMS (check all that apply) <input type="checkbox"/> Locking <input type="checkbox"/> Instability/giving way <input type="checkbox"/> Swelling <input type="checkbox"/> Pain with activity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Pain at rest/night: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Other: _____	TREATMENTS TO DATE (check all that apply) <input type="checkbox"/> Analgesics <input type="checkbox"/> Non-steroidal anti-inflammatory drugs <input type="checkbox"/> Injections: <input type="checkbox"/> Steroid <input type="checkbox"/> Viscosupplement <input type="checkbox"/> Arthroscopy <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Exercise/weight loss <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	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	EC Pt. ID#: _____	MRN#: _____
	Triage Code: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D	Triaged by: _____ Date: _____

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