



REQUEST FOR ORTHOPAEDIC CONSULTATION

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| 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)

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

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

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| Clinical Information | <p>CURRENT SYMPTOMS (check all that apply)</p> <p><input type="checkbox"/> Locking <input type="checkbox"/> Instability/giving way <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Pain with activity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p> <p><input type="checkbox"/> Pain at rest/night: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe</p> <p><input type="checkbox"/> Other: _____</p> | <p>TREATMENTS TO DATE (check all that apply)</p> <p><input type="checkbox"/> Analgesics <input type="checkbox"/> Non-steroidal anti-inflammatory drugs</p> <p><input type="checkbox"/> Injections: <input type="checkbox"/> Steroid <input type="checkbox"/> Viscosupplement</p> <p><input type="checkbox"/> Arthroscopy <input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Exercise/weight loss <input type="checkbox"/> Other: _____</p> |
| | <p>CURRENT ASSISTIVE DEVICES</p> <p><input type="checkbox"/> None <input type="checkbox"/> Cane(s) <input type="checkbox"/> Crutches</p> <p><input type="checkbox"/> Rollator/Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bedridden</p> | <p>CURRENT MEDICATIONS (please list or attach medication profile): _____</p> |

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