



Request for Orthopaedic Consultation Knee and Hip Arthritis Management

FAX: (855) 346-9138 All information above the double line must be complete.

CONSULTATION OPTIONS

Preferred Hospital (select one)

- Humber River Hospital
 Mackenzie Health
 Markham Stouffville Hospital
 North York General Hospital
 Southlake Regional Health Centre

Preferred Surgeon, Dr. Justin S. Chang _____ or First Available Surgeon

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: _____

Alternate Phone: _____

Email: _____

DIAGNOSIS:

- Osteoarthritis
 Inflammatory arthritis
 Post-traumatic arthritis
 Other: _____

REASON FOR REFERRAL:

- Primary Replacement:
 Hip Right / Left
 Knee Right / Left
URGENCY: Routine
 Urgent

X-RAY REPORTS OF THE AFFECTED JOINT MUST ACCOMPANY REFERRAL

If no X-ray report is available from within the last 12 months, we recommend the following views:

Knee: AP weight bearing, lateral of knee flexed at 30°, skyline

Hip: AP Pelvis, 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 & 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

COMPLETION OF THIS FORM WILL EXPEDITE YOUR REQUEST