

# Hip and Knee Arthritis Program

Toronto Central LHIN Joint Health and Disease Management Program

## 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 Toronto Central LHIN – 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"/> Mount Sinai Hospital (Fax: 416-586-8673)
<input type="checkbox"/> St. Joseph's Health Centre (Fax: 416-530-6032)	<input type="checkbox"/> St. Michael's Hospital (Fax: 416-864-5817)
<input type="checkbox"/> Toronto East General Hospital (Fax: 416-469-6424)	<input type="checkbox"/> Toronto Western Hospital (Fax: 416-603-5765)

**Dr.** \_\_\_\_\_ (identify orthopaedic surgeon and fax to hospital using fax numbers above)

Physician Information	<p><b>Referring Physician Information</b></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><b>Family Physician Information (if different)</b></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><b>DIAGNOSIS:</b> <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><b>CONSIDERATION FOR:</b></p> <p><input type="checkbox"/> Primary Replacement: <input type="checkbox"/> Hip <input type="checkbox"/> Knee</p> <p><input type="checkbox"/> Opinion on prior 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><b>URGENCY:</b> <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

Clinical Information	<p><b>CURRENT SYMPTOMS</b> (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><b>TREATMENTS TO DATE</b> (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><b>CURRENT ASSISTIVE DEVICES</b></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><b>CURRENT MEDICATIONS</b> (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?

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**Please forward any additional information that will assist us in determining urgency**

CI USE ONLY	TC Ref. ID# :	MRN#:
	Triage Code: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> G	Triaged by: _____ Date: _____

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