Musculoskeletal Central Intake & Assessment Centre
www.mskciac.ca
Phone 1-888-868-5568
Fax 1-888-556-0966

Referral Form – Hip/Knee Arthroplasty Assessment

Patients must be over 18 years of age at the time of assessment.

Referral Date: YYYY | MM | DD

Hip and Knee Orthopaedic Assessment Options - Patients are scheduled for **first available assessment** at the location closest to their home, or they can choose:

❒ First Available **or** ❒ Preferred Assessment Centre: ☐ Brantford ☐ Burlington ☐ Hamilton ☐ Niagara

If the patient is deemed surgical, indicate the patient's preference for:

❒ First Available Surgeon ❒ Specific Surgeon: ____________________

❒ Specific Hospital: ☐ BCHS ☐ HHS ☐ JBH ☐ NHS ☐ SJHH ☐ Other ____________

Referring Physician Information

Name: ____________________
Address: ____________________
____
Phone: ____________________
Fax: ____________________
Billing #: ____________________
Signature: ____________________

Patient Information

Name: ____________________
Address: ____________________
____
Date of Birth: ____________________
Health Card #: ______________VC: ______
Phone: ____________ Alt phone ____________
Gender: ☐ Male ☐ Female

Diagnosis: ☐ Hip Right / Left ☐ Knee Right / Left

☐ Moderate to severe Osteoarthritis
☐ Other inflammatory condition____________________
____

*Patient not eligible if mild OA.

Reason for Referral:

☐ Primary Replacement: ☐ Hip ☐ Knee

Preferred language

☐ English ☐ French ☐ Other ____________

Is a translator needed? ☐ **Yes** ☐ **No**

X-Ray Requirements (X-ray report must be attached.)

The following x-rays are to be taken and then reviewed by the referring physician, both within the last 6 months:

Knee: Standing AP, lateral and skyline
Hip: Ortho pelvis, AP and lateral shoot through.
Patients are required to bring their X-Rays to their appointment.
An MRI is not appropriate.

Medications & Medical History

Attach the cumulative patient profile and medical history.

Current Assistive Devices

☐ None ☐ Cane(s) ☐ Crutches
☐ Rollator/Walker ☐ Wheelchair ☐ Bedridden

Current Symptoms (check all that apply)

☐ Locking ☐ Instability/giving way ☐ Swelling
☐ Pain with activity: ☐ Mild ☐ Moderate ☐ Severe
☐ Pain at rest/night: ☐ Mild ☐ Moderate ☐ Severe
☐ Other: ____________________

Treatments to Date (check all that apply)

☐ Analgesics ☐ NSAIDs ☐ Bracing
☐ Physiotherapy ☐ Arthroscopy
☐ Injections: ☐ Steroid ☐ Viscosupplementation ☐ PRP
☐ Exercise/weight loss ☐ Other: ____________________

*Patient appropriate non-surgical treatments to be completed prior to referral.

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

For use by Central Intake Referral ID#: MRN#:

Triage code: Reviewed by: Date: