**![Logo_CBDHA[1]]()**

**Patient Demographics Label**

**OAC Hip and Knee Referral Form**

**THE FOLLOWING MUST BE COMPLETED PRIOR TO SENDING REFERRAL:**

 **ATTACHED RADIOGRAPHIC REPORT (COMPLETED IN THE LAST 6 MONTHS)**

 **KNEE VIEW: WEIGHTBEARING AP/LAT WITH SKYLINE PATELLA**

 **HIP VIEW: AP PELVIS WITH AP/LAT AFFECTED SIDE**

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| **REFERRAL REQUEST:** |

❑ 4-Week Hip & Knee Management Program ONLY

 **-OR-**

❑ Orthopaedic Surgeon Assessment + 4-Week Hip & Knee Management Program

*PLEASE ALSO SELECT:* ❑Next Available Surgeon **-OR-** Specific Surgeon:

❑Dr. D. Brien ❑Dr. K. Orrell

❑Dr. F. Dodd ❑Dr. M. O’Neill

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| **REASON FOR REFERRAL – AFFECTED JOINT(S):** |

❑ Left Hip ❑ Right Hip History of Injury and/or Trauma? ❑Yes ❑ No

❑ Left Knee ❑ Right Knee

*\*\*Does not include acute ligamentous injuries or revision arthroplasty*

*(Those referrals should continue to be sent directly to surgeon’s office)*

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| **ADDITIONAL PATIENT INFORMATION:** |

Please check the box that most accurately describes the patient’s situation over the last three months:

1. Ability to walk without significant pain: ❑ Unlimited ❑1-5 blocks ❑ <1block ❑ Household only
2. Highest level of walking support (**related to affected joint(s)**) the patient currently uses to carry out usual activities: ❑ None ❑ Brace/Cane ❑ Walker ❑ Wheelchair
3. Duration of symptoms: ❑ 0-6 Months ❑ 6-12 Months ❑ >12 Months
4. Pain during: Rest ❑ Intermittent ❑ Constant

 Activity ❑ Intermittent ❑ Constant

 Night ❑ Intermittent ❑ Constant

Non-Operative Treatment to Date: ❑ NSAIDS ❑ Physiotherapy ❑ Depo-medrol Injections ❑ Lifestyle

PMHx/Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Provider (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_