

Hip & Knee Arthroplasty Assessment Referral Form

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

Referral Date: DD MM YYYY

PREFERRED CLINIC LOCATION: The first available assessment at the location closest to their home, or they can choose:

☐ First Available assessment within the HNHB Region or

Preferred assessment location: ☐ Brantford ☐ Burlington ☐ Hamilton ☐ Niagara Falls

PREFERRED SURGEON (If a patient is deemed a surgical candidate):

☐ First Available Surgeon ☐ Preferred Surgeon: _____

Preferred Hospital: ☐ BCHS ☐ HHS ☐ JBH ☐ NHS ☐ SJHH ☐ Other: _____

PATIENT INFORMATION:

Name: _____ Date of Birth: _____ Gender: _____

Health Card: _____ Address: _____

Primary Phone: _____ City: _____ Postal Code: _____

Alternate Phone: _____ Email: _____

Preferred Language: ☐ English ☐ French ☐ Other: _____

Barriers to Communication: ☐ Cognitive Impairment ☐ Hearing Impairment ☐ Sight Impairment

☐ Other: _____

REFERRAL FOR PRIMARY REPLACEMENT OF:

Hip: ☐ Left ☐ Right ☐ Bilateral

Knee: ☐ Left ☐ Right ☐ Bilateral

DIAGNOSIS:

☐ Moderate to severe Osteoarthritis confirmed by x-ray imaging only

***Patient is not eligible if mild to moderate OA**

X-RAY REPORT (Required – images taken within the last 6 months):

- Attach the x-ray report of the affected joint(s) taken and reviewed by the referring provider, within the **last 6 months**.
- X-rays are the only accepted imaging - **MRIs are not accepted**

Please provide the following views:

Hip: Ortho pelvis, AP, and, lateral shoot through

Knee: Standing AP, lateral, and skyline

MEDICAL HISTORY & MEDICATIONS (Required): Attach the cumulative patient profile and medications.

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: _____

CURRENT ASSISSTIVE DEVICES (check all that apply):

☐ None ☐ Cane(s) ☐ Crutches

☐ Rollator/Walker ☐ Wheelchair ☐ Bedridden

TREATMENTS TO DATE (check all that apply):

☐ Analgesics ☐ NSAIDS ☐ Exercise/Weight Loss

☐ Physiotherapy ☐ Bracing ☐ Arthroscopy

Injections: ☐ Steroid ☐ Viscosupplementation ☐ PRP

☐ Other: _____

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

REFERRING PROVIDER: ☐ MD ☐ NP ☐ OTHER _____

Name: _____

Phone: _____

Address: _____

Fax: _____

Signature: _____

Billing #: _____

PRIMARY CARE PROVIDER (IF DIFFERENT THAN REFERRING): _____

Referrals are valid for one year from the referral date.