msk ciac
Musculoskeletal
Central Intake &
Assessment Centre

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Phone 1-888-868-5568
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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:

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