**Regional Hip and Knee Replacement Program**

Cornwall Community Hospital  Hôpital Montfort  Queensway Carleton Hospital

The Ottawa Hospital  Pembroke Regional Hospital

**Request For Consultation**

**Fax: 613-721-7889**

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| **REFERRAL DATE (YYYY/MM/DD):**  **\*INCOMPLETE REFERRALS WILL BE RETURNED**  **Services requested in:** □ **English** □ **French** | |
| **Referring Physician Information – may use stamp**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Billing #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Family Physician Information (if different)  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Patient Information – may use sticker**  Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female  Alternate Contact Information:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Clinical Information**  Diagnosis:  Hip: Right Left Bilateral  Knee: Right Left Bilateral   |  | | --- | | * Osteoarthritis | | * Inflammatory Arthritis | | * Post-traumatic Arthritis | | * Joint derangement not yet diagnosed | | * Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   **Patient-specific considerations:**   * NONE * Cognitive issues * Language barrier * Hearing impairment * Vision impairment * Other (Specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      |  |  |  | | --- | --- | --- | | Does the patient want surgery? | □ yes | □ no | | Appropriate for virtual visit? | □ yes | □ no | | **Treatment to Date**   |  |  | | --- | --- | | * None | * Physiotherapy | | * Weight loss | * GLA:D | | * Cortisone injections | * Medications | | * Visco injections | * Bracing | | * Cane/walker | * Exercise | | * Other: |  |   **Surgeon Preference**   * First Available Surgeon   □ Specific Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Diagnostic Imaging Required:**  **This referral MUST be accompanied by the imaging report otherwise IT WILL BE RETURNED.**  **We REQUIRE the following specific X-rays, completed within the last 3 months:**  **Hip:**   |  | | --- | | 1. **AP pelvis** | | 1. **Lateral of affected hip** |   **Knee:** **including WEIGHT-BEARING views**  **(please note that “routine” views of the knee ARE NOT weight-bearing)**   |  | | --- | | 1. **weight-bearing AP** | | 1. **weight-bearing flexion PA** | | 1. **lateral flexed at 30°** | | 1. **skyline view** | |