

# 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**

REFERRAL DATE (YYYY/MM/DD): _____	<b>*INCOMPLETE REFERRALS WILL BE RETURNED</b>
Services requested in: <input type="checkbox"/> English <input type="checkbox"/> French	Height: _____                      Weight: _____
<p><b>Referring Physician Information – may use stamp</b></p> <p>Name: _____</p> <p>Specialty: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Billing#: _____</p> <p>Signature: _____</p> <p>Family Physician Information (if different)</p> <p>Name: _____</p> <p>Phone: _____</p>	<p><b>Patient Information – may use sticker</b></p> <p>Name: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Email: _____</p> <p>Date of Birth: _____</p> <p>Health Card #: _____</p> <p>Gender:    <input type="checkbox"/> Male            <input type="checkbox"/> Female</p> <p>Alternate Contact Information:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Clinical Information</b></p> <p>Diagnosis:</p> <p>Hip:    <input type="checkbox"/> Right    <input type="checkbox"/> Left    <input type="checkbox"/> Bilateral</p> <p>Knee: <input type="checkbox"/> Right    <input type="checkbox"/> Left    <input type="checkbox"/> Bilateral</p> <p><input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> Inflammatory Arthritis</p> <p><input type="checkbox"/> Post-traumatic Arthritis</p> <p><input type="checkbox"/> Joint derangement not yet diagnosed</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> PREVIOUS VISIT(S) FOR SAME JOINT</p> <p><b>Patient-specific considerations:</b></p> <p><input type="checkbox"/> NONE</p> <p><input type="checkbox"/> Cognitive issues</p> <p><input type="checkbox"/> Language barrier</p> <p><input type="checkbox"/> Hearing impairment</p> <p><input type="checkbox"/> Vision impairment</p> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Does the patient want Surgery?    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Appropriate for virtual visit?      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p><b>Please attach cumulative patient profile (medical history) and co-morbidities, medications, and allergies.</b></p>	<p><b>Treatment to Date</b></p> <p><input type="checkbox"/> None    <input type="checkbox"/> Physiotherapy</p> <p><input type="checkbox"/> Weight loss                                    <input type="checkbox"/> GLA:D</p> <p><input type="checkbox"/> Cortisone injections                        <input type="checkbox"/> Medications</p> <p><input type="checkbox"/> Visco injections                              <input type="checkbox"/> Bracing</p> <p><input type="checkbox"/> Cane/walker                                  <input type="checkbox"/> Exercise</p> <p><input type="checkbox"/> Other: _____</p> <p><b>Surgeon Preference</b></p> <p><input type="checkbox"/> First Available Surgeon</p> <p><input type="checkbox"/> Specific Surgeon: _____</p> <p><b>Diagnostic Imaging Required:</b></p> <p><b>This referral MUST be accompanied by the imaging report otherwise IT WILL BE RETURNED.</b></p> <p><b>We REQUIRE the following specific X-rays, completed within the last 3 months:</b></p> <p><b>Hip:</b></p> <p>1. AP pelvis</p> <p>2. Lateral of affected hip</p> <p><b>Knee: including WEIGHT-BEARING views</b> (please note that "routine" views of the knee ARE NOT weight-bearing)</p> <p>1. Weight-bearing AP</p> <p>2. Weight-bearing flexion PA</p> <p>3. Lateral flexed at 30°</p> <p>4. Skyline view</p>