Toronto Region

Rapid Access Clinic Hip and Knee Arthritis

Ontario Health Toronto

REQUEST FOR ORTHOPAEDIC CONSULTATION

Referral Date:	YYYY	MM	DD

CONSULTATION REQUESTED FROM: (select one)
Note: if no selection is made, referral will be processed as "next available".

❑ **Next available appointment within any Toronto Region Hospital — FAX to (416) 599-4577**
Toll Free: 1-877-411-4577

❑ **Hospital (select hospital and fax to identified number):**

- ☐ Holland Orthopaedic & Arthritic Centre (Fax: 416-599-4577)
- ☐ Mount Sinai Hospital (Fax: 416-586-3213)
- ☐ St. Michael's Hospital (Fax: 416-864-5817)
- ☐ Michael Garron Hospital (Fax: 416-469-6145)
- ☐ St. Joseph's Health Centre (Fax: 416-530-6691)
- ☐ Toronto Western Hospital (Fax: 416-603-5765)

❑ **Dr.** _____ (identify orthopaedic surgeon and fax to hospital using fax numbers above)

Physician Information

Referring Physician Information

Name: _____
Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____
Email: _____
Billing #: _____
Signature: _____

Family Physician Information (if different)

Name: _____
Phone: _____

Patient Information

Name: _____
Address: _____
_____
Date of Birth: _____
Health Card #: _____ VC: ____

Gender: ☐ Male ☐ Female
Language if unable to speak English:
_____
Phone (Home): _____
Phone (Work): _____
Phone (Cell): _____
Email: _____
WSIB #: _____

Clinical Information

DIAGNOSIS: ☐ Hip Right / Left ☐ Knee Right / Left
☐ Osteoarthritis ☐ Inflammatory arthritis ☐ Fracture
☐ Post-traumatic arthritis ☐ Failed hip or knee replacement
☐ Joint derangement not yet diagnosed
☐ Other: _____

CONSIDERATION FOR:
☐ Primary Replacement: ☐ Hip ☐ Knee
☐ Opinion on prior replacement: ☐ Hip ☐ Knee
☐ Opinion Requested: ☐ Hip ☐ Knee
URGENCY: ☐ Routine ☐ Urgent

PLEASE ATTACH EXISTING X-RAY REPORTS OF THE AFFECTED JOINT
If no X-ray report is available from within the last 6 months, we recommend the following views:
Knee: AP weight bearing, lateral of knee flexed at 30°, skyline | **Hip**: AP pelvis, AP and lateral of affected hip

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 ☐ Non-steroidal anti-inflammatory drugs
☐ Injections: ☐ Steroid ☐ Viscosupplement
☐ Arthroscopy ☐ Physiotherapy
☐ Exercise/weight loss ☐ Other: _____

CURRENT ASSISTIVE DEVICES
☐ None ☐ Cane(s) ☐ Crutches
☐ Rollator/Walker ☐ Wheelchair ☐ Bedridden

CURRENT MEDICATIONS (please list or attach medication profile): _____
_____

Has there been a recent significant change in function (e.g., threat to independence), pain level and/or range of motion? Are there systemic signs (e.g., fever, chills)? Other significant issues?
_____

Please forward any additional information that will assist us in determining urgency

CI USE ONLY

EC Pt. ID#:		MRN#:	

Triage Code: ☐ A ☐ B ☐ C ☐ D | Triaged by: _____ Date:_____

Please note that **all areas ABOVE the double line MUST be completed**

Rev: April 2023