Hip and Knee Assessment Referral Form

Regional Joint Assessment Program

1-888-868-5568

Referral Date: ______________________________

Assessment Location:

☐ **Hamilton Site** (Fax to 905 521-2621)
☐ **Niagara Site** (Fax to 905 521-2621)
☐ **Brantford Site** (Fax to Dr. Woolfrey 519-751-5895)
(Fax to Dr. Dill 519-756-5576)

Surgeon preference:

☐ Dr. ___________________________ or

☐ Next Available Surgeon

REFERRING PHYSICIAN INFORMATION

Name: ______________________________
Address: ______________________________
City: ______________________________
Postal Code: ______________________________
Phone: ______________________________
Fax: ______________________________
Email: ______________________________
Billing #: ______________________________
Physician signature ______________________________

PATIENT INFORMATION

First Name: ______________________________
Last Name: ______________________________
Health Card #: __________________________vc:____
Gender: Male ☐ Female ☐
Date of Birth: ______________________________
Address: ______________________________
City: ______________________________
Postal Code: ______________________________
Phone: ______________________________

REASON FOR REFERRAL

Diagnosis ☐ Osteoarthritis ☐ Inflammatory Arthritis ☐ Other______________________

Affected Joint(s): **Hip**: ☐ Right ☐ Left ☐ Bilateral **Knee**: ☐ Right ☐ Left ☐ Bilateral

WSIB Patient: ☐ Y ☐ N WSIB #

MEDICATION AND MEDICAL HISTORY

Please list current medications or attach medication profile including non-prescription and herbal medications. Include any relevant medical history (cardiac, renal etc.) and test results.

****X-RAYS (to be completed within the past 3 months)**

Please ensure the following x-rays are completed PRIOR to the patient's scheduled appointment

Knee – standing AP, lateral and skyline **Hip- Ortho pelvis, AP and lateral shoot through**