



Regional Joint Assessment Centre-Hamilton Site

Fax - 905 521-2621



Hip and Knee Assessment Referral Form

PATIENT INFORMATION:

Last Name _____ First Name _____ Health Card # _____

Male _____ Female _____ Date of Birth _____ / _____ / _____
D M Y

Address: _____ City: _____ Postal Code: _____

Phone: () _____ Alt. Phone () _____

REFERRING PHYSICIAN INFORMATION:

Last Name _____ First Name _____ ULI: _____

Address: _____ City: _____ Postal Code: _____

Phone: () _____ Fax: _____ Email _____

REASON FOR REFERRAL:

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

Assign Patient To Next Available Surgeon? Yes No

If No: Requested Surgeon Name: Last _____ First _____

WSIB Patient- Indicate Y or N WSIB # _____

Please include any relevant medical history, test results, current medication list and include non-prescription and herbal.

If available please send x-rays that have been taken within 3 months with the patient. If not available, x-rays will be completed at the Regional Joint Assessment Centre.

Primary / Partial Knee: AP weight bearing, Lateral of knee with knee flexed at 90 degrees, Skyline.

Primary / Partial Hip: AP pelvis centered at pubis, AP and Lateral of proximal half of affected femur.

Referring Physician signature _____ Date: _____ / _____ / _____
D M Y