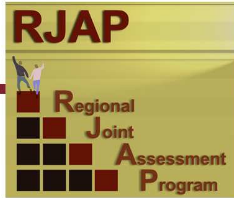
519 751-5544 ext. 2500



Regional Joint Assessment Program-Brantford Site

Fax referrals for Dr. Woolfrey to 519 751-5895

This program is part of the Hamilton, Niagara, Haldimand and Brant Local Health Integration Network

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____________________ FAX: ____________________________

REFERRAL INFORMATION:

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

Reason for referral/imaging results: ____

WSIB Patient Indicate Y or N WSIB # ____

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

X-RAYS are required for all patients **x-ray reports are NOT adequate

Please send x-ray films taken within 6 months with the patient. If films are not available, please arrange for the following:

Knee: AP weight bearing, lateral of knee with knee flexed at 90 degrees, Skyline
Hip: AP pelvis centered at pubis, AP and Lateral of proximal half of affected femur.
** Patients arriving without x-rays will be re-booked**

Referring Physician Signature__________________________________Date___________/__________/_____________ (**D** **M** **Y**)

NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA

Hamilton Health Sciences

St. Joseph's Healthcare Hamilton

JOSEPH BRANT MEMORIAL HOSPITAL