



Regional Joint Assessment Program

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

Referral Date: _____

Assessment Location :

- Hamilton Site** (Fax to 905 521-2621)
- Brantford Site** (Fax to Dr. Woolfrey 519-751-5894)
(Fax to Dr. Dill 519-756-5576)

Surgeon preference:

- Dr. _____ or
- Next Available Surgeon

REFERRING PHYSICIAN INFORMATION

PATIENT INFORMATION

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

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 Patient will be bringing x-rays that have been taken within the last 3 months and include the following views:
 Knee – Standing AP, lateral and skyline **Hip**- Ortho pelvis, AP and lateral of affected Hip or
 Patient will need x-rays done at appointment



NIAGARA HEALTH SYSTEM
SYSTÈME DE SANTÉ DE NIAGARA



Hamilton Health Sciences



St. Joseph's
Healthcare & Hamilton



JOSEPH BRANT
MEMORIAL HOSPITAL