

Affix patient label within this box

Hip and Knee Replacement Referral 

Please print, complete and return this form by fax to the appropriate clinic below. Attach the following with the completed form

- Relevant medical history/EMR Record
- X-ray report - **MRI is not required for this referral** X-ray reports attached
 - Knee: AP weight bearing, lateral of knee with knee flexed, Skyline
 - Hip: AP pelvis centered at pubis, AP and lateral of proximal half of affected femur

Patients must be on appropriate non-surgical treatment prior to evaluation (*e.g. medication, physiotherapy, walking aids, shoe inserts*).

Select One	Calgary Downtown Fax - 403.221.4387	Grande Prairie Fax - 780.402.9829	Red Deer Fax - 403.341.6990
	Calgary South Health Campus Fax - 403.956.3275	Lethbridge Fax - 403.942.0186	Westlock Fax - 1.844.908.1409
	Camrose Fax - 780.679.2630	Medicine Hat Fax - 403.528.8163	Bonnyville Fax - 780.826.6531
	Edmonton Fax - 780.432.6395		

Reason for Referral				
What is the primary reason you are referring this patient? _____				
Primary Affected Joint(s) <input checked="" type="checkbox"/>	Right	Left	Bilateral	Type of Problem
Hip				<input type="checkbox"/> Primary
Knee				<input type="checkbox"/> Revision
Duration of Symptoms <input type="checkbox"/> 3 - 6 months <input type="checkbox"/> 6 - 12 months <input type="checkbox"/> Years <input type="checkbox"/> Other (<i>specify</i>) _____				Is this a WCB claim? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify claim number _____
Will you be assigning the patient to the next available surgeon? <input type="checkbox"/> No, specify surgeon name (<i>last, first</i>) _____ <input type="checkbox"/> Yes				
Height _____ cm		Weight _____ kg		BMI _____

Previous Orthopaedic Surgeries			
Has the patient undergone any previous orthopaedic surgeries? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete ►	Surgery	Surgeon	Year
Is the patient currently controlling joint pain with medication? <input type="checkbox"/> No <input type="checkbox"/> Yes, complete ►	<input type="checkbox"/> Narcotics <input type="checkbox"/> Over the counter <input type="checkbox"/> NSAID/COXIB <input type="checkbox"/> Other (<i>specify</i>) _____		
Comments			

Check appropriate boxes	None	Mild	Moderate	Severe
Pain on motion (e.g. walking, bending)				
Pain at rest (e.g. while sitting, lying down, or causing sleep disturbance)				
Other functional limitations (e.g. putting on shoes, managing stairs, sitting to standing, sexual activity, bathing, cooking, recreation or hobbies)				
Abnormal findings on physical exam related to most severely affected joint (e.g. deformity, instability, leg length difference, restriction of range of motion on exam)				
Highest level of walking supports (for the affected joint that patient currently uses to carry out usual activities e.g. work, leisure) <input type="checkbox"/> None/Orthotics <input type="checkbox"/> Brace/Cane <input type="checkbox"/> Crutches/Walker <input type="checkbox"/> Wheelchair				
Highest level of medication to manage affected joint <input type="checkbox"/> PRN pain medication <input type="checkbox"/> Regularly-scheduled medication use <input type="checkbox"/> Maximum medical therapy appropriate for patient				
Ability to walk without significant pain <input type="checkbox"/> Over 5 blocks <input type="checkbox"/> 1-5 blocks <input type="checkbox"/> Less than 1 block <input type="checkbox"/> Household ambulator				
Threat to patient role and independence in society (i.e. ability to work, give care to dependents, live independently) Must relate to affected joint <input type="checkbox"/> Not threatened but more difficult <input type="checkbox"/> Threatened but not immediately <input type="checkbox"/> Immediately threatened or unable				
Rate the level of medical complexity of the patient (based on number and/or severity of key comorbid conditions, excluding hip/knee condition) <input type="checkbox"/> No medical problems <input type="checkbox"/> Current mild medical problems or past significant medical problems <input type="checkbox"/> Moderate medical disability or morbidity/requires "first line" therapy <input type="checkbox"/> Severe/constant significant disability/"uncontrollable" constant medical problems <input type="checkbox"/> Extremely severe/immediate treatment required/end organ failure/severe impairment of function				

Referring Clinician Information (complete or use practice stamp below)		
Name	PRACID	Practice Stamp (if applicable)
Address		
Phone	Fax	
Signature	Date (yyyy-Mon-dd)	